# MOUNT ELIZABETH NOVENA HOSPITAL

A registered business of Parkway Hospitals Singapore Pte Ltd

Business Reg No : 53206920W

## AGREEMENT FOR HOSPITAL SERVICES

| | |
|---|---|
| Patient Name | : PHUA QING HONG BYRAN |
| Case No. | : 4021011345 |
| MR No. | : 400206845 |
| Customer No. | : 0006264173 |
| Date of Estimation | : 16.02.2021 |
| Package Name | : Non-Package |
| Doctor's Name | : 10052H DR KANNAN KALIYAPERUMAL |
| ICD Code/Diagnosis | : NIL |
| | : NIL |
| | : NIL |
| Operation Code | : SB801B , Bone (Lower Limb), Deformities, Corrective Surgery with Inte |
| | : NIL |
| | : NIL |

EXCLUDES :

| | |
|---|---|
| CT SCAN | $1,000 -$3,000 |
| MRI | $1,500 - $6,000 |
| ULTRASOUND | $300 - $1,000 |
| XRAY | $100 - $600 |
| PET SCAN | $3,000-$8,000 |

| | | Lower Range | Upper Range |
|---|---|---|---|
| Estimated Length of Stay(days) | : | 001 | |
| Room Type | : | SINGLE BED | |
| Daily Room Rate | : S$ | 717.76 | |
| Daily Treatment Fee Rate | : S$ | 194.39 | |
| **ESTIMATED HOSPITAL CHARGES** | : S$ | 6,904.00 | 10,356.00 |
| **GST** | : S$ | 483.28 | 724.92 |
| Estimated Doctor's Consultation Fee | : | Please Consult Doctor | Please Consult Doctor |
| Estimated Doctor's Operation Fee | : | Please Consult Doctor | Please Consult Doctor |
| **TOTAL ESTIMATED DOCTOR'S CHARGES** | : | Please Consult Doctor | Please Consult Doctor |
| **TOTAL ESTIMATED HOSPITAL CHARGES** | : S$ | 7,387.28 | 11,080.92 |
| **ESTIMATED MEDISAVE CLAIMABLE AMOUNTS** | : S$ | 0.00 | |
| **PAYMENT REQUIRED ON ADMISSION** | : S$ | 6,904.00 | |

### 1. SCOPE OF HOSPITAL'S SERVICES:

The undersigned expressly requests that the Hospital provide hospital services and facilities to him/her/the patient. The undersigned understands that the preliminary/working diagnosis may only represent the patient's doctor's preliminary view of the patient's medical condition.

It is in the contemplation of the parties that such hospital services/facilities shall encompass all services/facilities provided to the patient regardless of whether such services/facilities were requested by the patient or his/her parents/spouse/next of kin/guardian or instructed or ordered by the patient's doctor(s) or otherwise. For the avoidance of doubt, such hospital services/facilities shall include any services/facilities provided in relation to the diagnosis, treatment or management of any medical condition (whether related to the preliminary/working diagnosis or otherwise).

### 2. FINANCIAL OBLIGATION:

The undersigned is liable to pay the Hospital immediately upon the issuance by the Hospital of an invoice, the charges as stated in the invoice for all hospital services rendered/facilities and expenses incurred by the Hospital in relation to the patient regardless of whether such charges or services or expenses arise from or are related to the preliminary and working diagnosis ("the Charges"). For the avoidance of doubt, the Charges do not refer to the total amount of charges stated in the estimates of charges set out above or to only the charges for diagnosis, treatment and management of the preliminary/working diagnosis, and the undersigned's obligation to pay the Hospital shall not be limited in any way by the estimates of charges set out above.

In the event that the undersigned fails to pay the Charges in full when due, the Hospital reserves the right to charge interest at the Hospital's then prevailing interest rate on the outstanding sum from the date of the invoice until payment of the said sum is made in full to the Hospital, subject to a minimum interest payment of S$10.00.

Where the undersigned's/patient's doctor(s) involved in treatment of the undersigned/the patient instructs the Hospital to assist such doctor(s) in the collection of the doctor's/doctors' charges from the undersigned/patient and the Hospital purports to do so, the undersigned agrees that the Hospital shall have the right but not the obligation to apply any payments made by the undersigned towards settlement of the Charges and/or the doctor's/doctors' charges, in such proportion between the Hospital and the doctor(s) as the Hospital in its sole discretion deems fit, unless the undersigned or payor has given the Hospital specific prior written instructions regarding the application of the funds paid towards the Charges or the doctor's or doctors' charges.

The Hospital may from time to time issue one or more invoice(s) for the hospital services and facilities rendered to the patient. For accounting purposes, if the patient is not discharged at the time of the issuance of an invoice, the Hospital may issue a new Case No. to the patient and the "Admission Date" stated on the next invoice issued may not be the actual admission date of the patient. Notwithstanding the above, this Agreement shall continue to bind the undersigned and have full force and effect. In particular, the undersigned shall continue to be liable to pay the Charges to the Hospital and/or to fully settle all invoices rendered by the Hospital.

The undersigned agrees to pay the Hospital's legal fees and expenses on an indemnity basis incurred in connection with any demand made or legal proceedings instituted to recover the Charges or any part thereof.

The undersigned further authorizes the Hospital to apply any excess funds after payments in full of the Charges for any other hospitalization and/or other services rendered and expenses incurred towards any other outstanding account which the patient may have with any of the hospitals and/or establishments of Parkway Holdings Limited and its related companies (as defined in the Companies Act, Cap.50)("the Parkway Group") for any prior and/or subsequent services rendered and for which the undersigned is responsible. In the event that there are still excess funds remaining with the Hospital after aforesaid payments, we will process the funds according to our refund policy. For payments by credit card, the excess funds will be credited back to the respective cards accordingly. Cheques will be issued for payments made by NETS, cash, cheque or GIRO. The Mode of Refund (MOR) form must be completed if you wish to request for an alternate refund instruction. By completing the MOR, the undersigned hereby unconditionally authorizes the Hospital to refund the net excess funds at any time as the Hospital deems fit and payment thereof by the Hospital shall constitute a full and valid discharge of its obligations to the undersigned. This authorization shall remain valid and effective until and unless revoked by notice in writing from the undersigned to the Hospital.

**3. BILL ESTIMATION:**

The above total estimated hospital charges and estimated length of stay are at best estimates only which includes the daily treatment fee as stated above. These are based on previous hospital patients with similar diagnosis and treatment as that stated in the preliminary/working diagnosis and the estimates do not take into account any complication(s) which may arise in the course of the diagnosis, treatment or management of the patient or any medical condition which may arise or be discovered, whether foreseeable or not and howsoever caused during the period of the diagnosis, treatment or management of the patient.

The undersigned acknowledges that the actual charges for all hospitalization and other services rendered and expenses incurred by the Hospital in relation to the patient and payable by the undersigned to the Hospital may differ from the above total estimated hospital charges depending on the final diagnosis, the patient's medical condition, actual treatment provided (including but not limited to the treatment of any complications that may arise or the treatment of any other condition that may be discovered during the patient's stay), and the actual length of stay in the Hospital.

The Hospital does not warrant that the actual charges payable for services and treatment provided to the patient and expenses incurred will be limited to that arising out of the Preliminary/Working Diagnosis only. No statement by the Hospital staff relating to the estimated total hospital charges shall be construed as a representation to the undersigned or a term of this agreement and any such statement shall not be binding on the Hospital unless set out in writing herein.

As the treatment for the patient is provided by doctor(s) who are not employees or agents of the Hospital, the undersigned should obtain an estimate of his/her/the patient's doctor(s) charges from the doctor(s) including the charges in the event of any complication(s) which may arise in the course of the diagnosis, treatment or management of the patient and also verify with the doctor(s) the estimated length of stay.

Estimated Medisave claimable refers to the estimated maximum amount that can be claimed from Medisave for hospital's and doctor's fees. However, Medisave regulations limit the withdrawal rates and this is also subjected to the availability of Medisave funds. The undersigned acknowledges that he/she has a clear understanding of the above information provided for by the Hospital.

**4. DISCHARGE OF PATIENT:**

The undersigned agrees that the Hospital is entitled to discharge the patient from the Hospital or transfer the patient from the Hospital to another hospital if the undersigned fails to pay the Charges in full when due and/or if the undersigned fails to provide any additional deposit(s) as required by the Hospital. For the avoidance of doubt, the Hospital's right to claim for the outstanding Charges is not affected or prejudiced by such discharge or transfer.

**5. MEDISAVE CLAIM:**

The Medisave Claims Authorisation Form and its supporting documents must be submitted while the patient is in the Hospital. If the said forms are not submitted by the time of the patient's discharge from the Hospital the patient is required to settle his/her bill and make any such claim against the bill within 3 days from his/her discharge. Should the patient change his/her mind about Medisave utilisation, the Hospital will not be obligated to entertain any claim after such period, but should the Hospital accede to assist in such claim, the undersigned agrees to bear the re-submission costs at the rate of 2.5%/month on the Medisave claim (or at such prevailing rate as may be imposed by the CPF Board), such costs to be deducted by CPF Board through the undersigned's Medisave account.

**6. NON-UTILISATION OF MEDISHIELD HEALTH INSURANCE (PMI):**

Where the undersigned has instructed the Hospital that he/she does not wish to use his/her Medishield Health Insurance for the payment of the hospital charges, the Hospital shall not be obligated to accede to any subsequent requests for submission of the said Health insurance claim after the patient's discharge from the Hospital. Should the undersigned change his/her mind to re-activate his/her Medishield Health Insurance, he/she must inform the Hospital and re-sign the necessary documents.

**7. DEPOSITS REQUIRED:**

☐ YES ☐ NO AMOUNT $_____

Transfer to ICU / HDU a deposit amount of **$20,000** will be required.

The Hospital has the right to require the undersigned to provide additional deposits from time to time.

Where the patient's doctor(s) involved in the treatment of the undersigned/patient instructs the Hospital to assist such doctor(s) in the collection of the doctor's or doctors' charges, the undersigned agrees that the Hospital shall have the right but not the obligation to apply the deposit(s) towards settlement of the Charges and/or the doctor's /doctors' charges, in such proportion between the Hospital and the doctor(s) as the Hospital in its sole discretion deems fit.

**8. HOSPITAL VISITING TIME:**

The Hospital's visiting hours (other than ICU/HDU) are from 8am - 8pm. For ICU/HDU, the visiting hours are from 12pm - 2pm & 5pm - 7.30pm.

**9. HOSPITAL CHECK-OUT TIME:**

The Hospital's check-out time is 11am. If the patient has to stay in his/her room after 11 am but leaves before 8pm the patient will be served lunch, afternoon tea and dinner and charged an additional half-day rate.

## 10. AFTER HOURS CHARGES:

A surcharge in accordance with the prevailing rates and terms of the Hospital will be levied for the following services rendered on Sundays and Public Holidays and outside the office hours of 8.30 am to 5 pm on Mondays to Fridays and 8.30 am to 1 pm on Saturdays Laboratory, Radiology, Rehabilitation, Ambulance, Resident Medical Officer's consultation. For Operating Theatres, a surcharge in accordance with the said prevailing rates and terms will be levied between 8 pm and end after 10pm for Monday to Saturday and whole day surcharge for Sunday and PH. For eye laser procedure a surcharge in accordance with the said prevailing rates and terms will be levied from 6pm to 7am (next day) for Monday to Friday and for cases that start before 7am and start after 1230pm on Saturday. Charges are applicable to visitors who stay overnight.

## 11. ALLOCATION OF ROOM-TYPE:

The undersigned consents that he/she/the patient be provided with an alternative room-type should the original choice of room be unavailable during admission. The undersigned authorizes the Hospital to transfer him/her/the patient's to his/her/the patient's choice of room-type once it becomes available and/or otherwise, agrees to bear any excess charges arising from the room conversion.

## 12. DAMAGE TO/LOSS OF HOSPITAL PROPERTY:

The undersigned shall be liable for the cost of repair or replacement of hospital property which is damaged or lost by the patient or by his/her relatives, friends or visitors.

## 13. PERSONAL VALUABLES/SAFE DEPOSIT BOX:

The Hospital shall not be liable for loss or damage, howsoever caused, to any monies, jewellery, documents, clothing or other personal properties belonging to the patient, including without limitation such property left in the hospital safe, which shall be left in the Hospital at the patient's own risk. Please approach Concierge for Safe Deposit Box service.

## 14. GENERAL CONSENT:

The undersigned hereby consents to his/her/the patient's admission to the Hospital for diagnostic procedures, medical, surgical and/or other treatment for his/her/the patient's condition as may be determined by the patient's doctor(s) during the course of the patient's stay in the Hospital (not limited to the Preliminary/Working Diagnosis). A separate informed consent is required for surgical, invasive and blood transfusion procedures. The doctors shall explain and get the consent from the patient either in the clinic or as an inpatient. The undersigned irrevocably and unconditionally authorises:-

(a) the Hospital and its staff and medical practitioners accredited to practise at any of the hospitals and/or establishments of the Parkway Group to have access to and to use any of the information and details relating to the patient, whether or not contained in the patient's medical and/or other records kept with or by the Hospital and its staff and/or medical practitioners accredited to practise at any of the hospitals and/or establishments of the Parkway Group;

(b) the collection, use, disclosure and/or processing of his/her/ the patient's personal data for purposes reasonably required by the Parkway Group and their respective business partners and agents to enable them to provide him/her/the patient with medical care and treatment. Such purposes are set out in greater detail in the Parkway Data Privacy Policy, which is accessible at https://www.parkwaypantai.com/privacy.html or available on request

(c) the use, transfer and/or release of all or any of the patient's information and medical and/or other records between and among all hospitals and/or establishments of the Parkway Group, in order to provide you better care and services including billing, administration and evaluative purposes and

(d) the release and disclosure of all or any of the patient's information and medical and other records to: (i) whoever as required by law; (ii) the Ministry of Health or any other relevant government authority; and (iii) such person(s) as may require the same to facilitate the performance of any required Medisave audit activity or any other audit or review sanctioned by the Hospital's Medical Advisory Board and/or Administration.

(e) the disclosure of all or any of the patient's information and medical and other records to any agent, contractor and/or sub-contractor of the Hospital and/or the Parkway Group for and in relation to the performance of the services under this agreement

The undersigned certifies that he/she has read the above terms and conditions, received a copy thereof and agrees to be bound thereunder.

AGREEMENT BY PATIENT :

SIGNATURE/THUMB PRINT & DATE

Where patient is for some reason* unable to sign the above, the undersigned warrants that he/she has the patient's authority to accept the aforegoing terms and conditions on behalf of the patient and does accept all the aforegoing terms and conditions on the patient's behalf.

*State reason: _____

Agreement by *Parent/Spouse/Next-of-Kin/Guardian (*Delete where inapplicable)

FULL NAME (BLOCK LETTERS) | NRIC/PASSPORT NO. | SIGNATURE/THUMB PRINT & DATE

ADDRESS

UNDERTAKING (PERSON OTHER THAN PATIENT)

In consideration of your admitting and/or rendering hospital services/facilities to the patient at my request, I hereby declare that I am not an undischarged bankrupt and agree to all the terms in sections 1 to 14 above and undertake to be liable and/or jointly and severally liable with the patient to pay the Hospital the Charges and to be similarly liable for any interest chargeable and/or legal fees and expenses as set out in section 1 above.

I confirm that this undertaking shall not be limited in any way by the estimated total hospital charges above and I confirm that I am liable to pay the Charges to the Hospital forthwith upon the issuance by the Hospital of any invoice based on the final diagnosis, the patient's medical condition(s), actual treatment or services/facilities provided (including but not limited to the diagnosis, treatment or management of any medical condition whether related to the preliminary/working diagnosis or otherwise and the diagnosis, treatment or management of any complication(s) or medical condition(s), whether foreseeable or not and howsoever caused), and the actual length of stay in the hospital, interests and/or legal fees and expenses as set out in section 2 above, without any legal set-off, equitable set-off or counterclaim.

For accounting purposes, if the patient is not discharged at the time of the issuance of an invoice, the Hospital may issue a new Case No. to the patient and the "Admission Date" stated on the next invoice issued may not be the actual admission date of the patient. Notwithstanding the above, I confirm that this undertaking shall continue to bind me and that it shall be my continuing obligation to pay the Charges to the Hospital and/or to fully settle all invoices rendered by the Hospital.

I further confirm that my agreement hereunder is an independent obligation which shall continue in full force and effect notwithstanding that the patient or the person authorized by the patient to sign on his/her behalf (as the case may be) is unable or unavailable for whatever reason to sign this document.

FULL NAME (BLOCK LETTERS) | NRIC/PASSPORT NO. | SIGNATURE/THUMB PRINT & DATE

Translated by the undersigned into _____ (state language) to the _____ (name(s) of person(s)) who confirms that he/she understands and agrees to the aforegoing terms and conditions.

FULL NAME (BLOCK LETTERS) | NRIC/PASSPORT NO. | SIGNATURE/THUMB PRINT & DATE

WITNESS BY: Diana Binte Mohamed — Snr Patient Account Officer, Business Office — 16/02/2021

NAME | SIGNATURE/THUMB PRINT & DATE