CLINIQUES DE L'EUROPE
EUROPA ZIEKENHUIZEN
advanced care - personal touch

Patient : «PAT_PAT_ID»
Name : «PAT_LASTNAME»
Firstname : «PAT_FIRSTNAME»
Dossier : «VIS_VISIT_ID» Admission date :«VIS_ADM_DATE»

CODE WIFI : USER = «VIS_VISIT_ID» PASS = date of birth in format DDMMYYYY

admission declaration form for day hospitalization

☐ **The Europe Hospitals attaches great importance to the quality of the care provided. Therefore we ask your permission to participate in a satisfaction survey that will run over a period of 2 years. Your participation means that your e-mail address with your data will be sent safely to the firm Bing, who will process your satisfaction form and keep your data for a period of 6 months. Afterwards it will be destroyed. This survey enables the hospital to improve the quality of care. For more information, please refer to our privacy policy. Thank you in advance for your permission.**

1. Purpose of the declaration : to provide you with the information you need to be able to make informed choices about the financial implications of the admission

All stays in day hospitalization involve costs. This document is designed to allow you to make certain choices. As these choices are significant factors for determining the final cost of your stay in hospital you should carefully read through the accompanying explanatory form before filling in and signing the declaration. If you have any questions, please do not hesitate to get in touch with **the patient administration department on 02/614.26.60**, for details about the hospital costs, or contact **your specialist doctor** for inquiries about the medical treatment or pay a visit to **the inscription/hospitalization department**

2. Choice of room

I am entitled to choose my doctor irrespective of the type of room I stay in.
I would like to be admitted and treated :

Without any additional fees or room supplements in a : ☐ ***shared room*** ☐ ***two-bed room***

☐ **private room**
Subject to a room supplement of € 150/day, € 170 or € 190/day in a maternity unit, € 220/day for a room in the private suites unit, € 330/day for a suite in the private suites unit.
I acknowledge that if I am admitted into a private room, the attending physicians may charge **an additional fee up to a maximum 200%** of the statutory rate for medical services.

3. Child accompanied by a parent during the child's stay in hospital

☐ I would like my child, who I will be accompanying, to be admitted and treated at the statutory rate, **without any additional fees and without any room supplement. I acknowledge that my child will be staying in *a two-bed room or in a shared room.***

☐ I expressly request that my child, who I will be accompanying, be admitted and treated **in a private room, without any room supplements** I agree that should my child be admitted into **a private room**, the attending physicians may charge an **additional fee up to a maximum 200%** of the statutory rate for medical services.
My **accommodation expenses as a parent accompanying a child** (including bed, meals, beverages, ..] **will be charged to** me at the rate specified in the overview of charges for common products and services.

4. Deposit

☐ I hereby pay €…….. as a sum paid in advance for my stay

The deposit will be deducted from the total value of the patient's invoice during the final settlement of accounts.

5. Payment terms and conditions

No direct payments should ever be paid to doctors for the medical services, as the hospital will issue an invoice for all the hospital expenses!

The payment terms and conditions (payment method, payment period, consequences of a failure to pay within the period of time laid down] are explained on the website (http://www.europehospitals.be]. All patients are entitled to seek information about the financial implications of their hospital stay and the type of room chosen. All patients have the right to seek information from the relevant doctor about the costs they will be charged for the planned medical services. I hereby acknowledge having received the explanatory form accompanying this declaration referring to the fees and room supplements. The overview of charges for products and services the hospital provides is available for consultation. I realize that not all the costs can be anticipated.

Done in duplicate in UCCLE/ETTERBEEK (delete where appropriate), on «PRINT_DATE» for a hospital stay starting on «VIS_ADM_DATE» and finish on «VIS_ADM_DATE»

For the patient or the patient's representative	For the hospital
	«PERSON_FIRST_NAME» «PERSON_LAST_NAME»
First name, last name of the patient or the patient's representative + signature (**with National Register N°**)	First name, last name and status

The hospital administrator requires this personal information to ensure your case and the invoice for your stay in hospital are duly processed. Pursuant to the Law of 08/12/1992 on privacy protection you are entitled to consult your data and correct them if need be.