

PARENTS INFORMATION
(on the expected cost of care)

Patient name:.....
Place and date of birth:.....; year ... month ... day
Nationality:.....
Address:.....
Document: (passport, identity card, driving licence, insurance card).....
Name of legal representative:
Address:.....

Dear Legal Representative!

The cost of care for patients who do not have Hungarian (or equivalent) health insurance is borne by the patient concerned (legal representative). The cost is determined on the basis of the fee regulations. Accordingly, the expected cost of your treatment is:.....HUF
Other:

Budapest, 20..... year month day

.....
signature of the informing doctor P.H.

I agree to pay the estimated cost of the treatment, the amount will be paid before/after/ day of hospital admission/ day of discharge. I will pay any costs other than the anticipated costs by the day of discharge/.....

Budapest, 20..... year month day

Debt acknowledgement statement

Signed.....
(Place of birth..... Date of birth:.....
Address.....)
as **legal representative**, I acknowledge that the **Patient** in my care

From to..... (day, month, year)
was receiving medical treatment at Bethesda Children's Hospital and I have not been fully reimbursed for the costs of treatment and care at the time of discharge from the hospital.

In this connection, I acknowledge that I owe a total amount of ,- HUF, in respect of the reimbursement of the fees.

I declare that I have been properly informed of the information concerning the calculation of the fee and the amount of the debt.

Budapest, 20.....

.....
Signature of legal representative

Information

Dear Parent/Member of the family!

Welcome to Bethesda Children's Hospital.

Our healing community is working to provide the highest quality and standard of care for your child. In our care and medical work, we strive to consider your child's spiritual, mental and physical needs.

To receive for free care, your child must have a valid Taj card or equivalent insurance. Please present this document together with your identification document at patient registration.

If your insurance card is not valid for any reason, please contact the relevant Government Office/insurer, etc. to rectify the problem.

In this case, we will also provide care for your child, but we will charge a fee for the interventions and tests performed.

You can find a price list for this in our Fee Policy at <https://www.bethesda.hu/rolunk/kozerdeku-szabalyzatok-letoltheto-dokumentumok/>.

If you do not have a valid Taj card or equivalent insurance, you will be charged a fee based on the tests/interventions performed. For a price list and how the fee is calculated, please refer to the Fee Policy.

You can pay the fee for the tests/interventions performed as follows:

at the cash desk during opening hours Mon-Fri 7 am to 3 pm, and during on-call hours using the card reader located at the reception of the premises.

Please note that failure to pay will have legal consequences.

In any case, you will be asked to sign a declaration of commitment to pay the fee before the start of the treatment.

Please send any comments on billing, requests for payment in instalments/equitable payment to Betegkapcsolatok@bethesda.hu.

Bethesda Children's Hospital Healing Community

Budapest, 2024.04.01.