醫療費用預算表 Medical Expense Estimation Form

bowtie

費用預算只供參考，最終收費視乎病人實際接受的治療、程序及服務而定。

The estimated expense are for reference only. Final payments are subject to expense incurred from medical treatment, procedures and services performed.

保單號碼
Policy Number:

Part 1. 治療詳情 (由主診醫生填寫) Treatment Details (To be completed by attending physician)

病人姓名 Name of Patient	身份證號碼 Identity card/HKID card
醫院名稱 Name of Hospital	
主診醫生 Attending Physician	預計住院時間 Estimated length of stay _____ 日 Days

病房級別 Ward Type
☐ 私家房 Private ☐ 半私家房 Semi-Private ☐ 標準房 Ward ☐ 門診/日間手術 Outpatient /Day surgery ☐ 其他 Others: _____

初步診斷 Provisional Diagnosis	治療 / 手術 Treatment and Surgery

Part 2. 預算醫生費用 (由主診醫生填寫) Estimated Doctor's Fee (To be completed by attending physician)

每日醫生巡房費 Daily Doctor's Round Fee	$ _____	×	_____ 日 Days
手術費 Surgical Fee	$ _____		
麻醉科醫生費 Anaesthetist's Fee	$ _____		
其他專科醫生診療費用 (請註明) Other Specialists' Consultation Fee (Please Specify)	$ _____		
其他項目及收費(請註明) Other Items and Charges (Please Specify)	$ _____		

Part 3. 預算醫院費用 (由主診醫生根據醫院提供的收費資料填寫) Estimated Hospital Charges (To be completed by attending physician based on the charges information provided by hospital)

住宿費用 Room Charges	$ _____	×	_____ 日 Days
手術室及相關物料費用 Operating Theatre and Associated Materials Charges	$ _____		
其他項目及收費 Other Items and Charges	$ _____		

本人已向病人 / 直系親屬 / 獲授權人士解釋上述預算費用，並徵得其同意。

I have explained to the patient / next-of-kin / authorized person details of the above estimated charges and have sought his / her agreement.

醫生姓名 Name of Attending Physician _____	醫生簽署 Signature of Attending Physician _____	簽署日期 Sign Date _____

Part 4. 病人簽署 Patient Signature

本人知悉預算費用並無法律效力，僅為參考，並不包括因併發症以及入院後發現的疾病所產生的額外費用。本人同意最終收費視乎病人實際接受的治療、程序及服務而定，並以醫院帳單所列為準。

I understand that this estimation is not legally binding and is for reference only. Additional charges incurred from complications and from disease diagnosed after admission are not covered. I agree that final payments are subject to charges incurred from treatment, procedures and services performed and should be made in accordance with hospital invoice.

病人 / 直系親屬 / 獲授權人士姓名 Name of Patient / Next-of-kin / Authorized Person	病人 / 直系親屬 / 獲授權人士簽署 Signature of Patient / Next-of-kin / Authorized Person	簽署日期 Sign Date