|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **ANNEX A** | | | | | | | | | | | | | | | |
| **STATEMENT OF ACCOUNT** | | | | | | | | | | | | | | | |
| **SOA REFERENCE NO.:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | | | | | |
|  |  | |  | |  | |  | |  | |  | |  | |  |
| Republic of the Philippines  Province of Cavite  CITY OF GENERAL TRIAS  OFFICE OF THE CITY HEALTH OFFICER  **GEN. TRIAS CHO ANIMAL BITE TREATMENT CENTER** | | | | | | | | | | | | | | | |
| **HOSPITAL RD., BRGY. PINAGTIPUNAN, GEN. TRIAS, CAVITE** | | | | | | | | | | | | | | | |
| **TEL. NO: (046) 509-5289**  ${d0\_date} 08:00 AM  ${name} | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
| **PATIENT NAME : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE & TIME ADMITTED: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  ${address}  ${d0\_date} 11:00 AM | | | | | | | | | | | | | | | |
| **ADDRESS : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE & TIME DISCHARGED: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  90375 ${icd10}  ${diagnosis} | | | | | | | | | | | | | | | |
| **FINAL DIAGNOSIS : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FIRST CASE RATE : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | | | | | |
| **OTHER DIAGNOSIS : 1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SECOND CASE RATE (IF APPLICABLE): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | | | | | |
| **SUMMARY OF FEES** | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
| **PARTICULARS** | | **ACTUAL CHARGES** | | **AMOUNT OF DISCOUNTS** | | | | | | **PHILHEALTH BENEFITS** | | | | |  |
|  |
| **VAT EXEMPT** | | **SENIOR CITIZEN / PWD** | | **PLACE √ \_\_\_\_\_ PCSO \_\_\_\_\_DSWD \_\_\_\_\_\_DOH \_\_\_\_\_\_HMO OTHERS: \_\_\_\_\_\_\_\_\_** | | **FIRST CASE RATE AMOUNT** | | **SECOND CASE RATE AMOUNT** | | **OUT OF POCKET OF PATIENT** |  |
| **HCI FEES** | |  | |  | |  | |  | | **PHP 3510.00** | |  | |  |  |
| **ROOM & BOARD** | |  | |  | |  | |  | |  | |  | |  |  |
| **DRUGS & MEDICINE** | |  | |  | |  | |  | |  | |  | |  |  |
| **( ERIG EQUINE ANTI RABIES SERUM )** | | **PHP 1800.00** | |  |
| **ANTI RABIES VACCINE (INACTIVATED)** | | **PHP 2600.00** | |  |
| **LABORATORY & DIAGNOSTIC** | | **N/A** | |  | |  | |  | |  | |  | |  |  |
| **OPERATING ROOM FEE** | | **N/A** | |  | |  | |  | |  | |  | |  |  |
| **SUPPLIES** | |  | |  | |  | |  | |  | |  | |  |  |
| **OTHERS PLS. SPECIFY** | | **N/A** | |  | |  | |  | |  | |  | |  |  |
| **SUBTOTAL** | | **PHP 4400.00** | | **N/A** | | **N/A** | | **N/A** | | **PHP 3900.00** | | **N/A** | |  |  |
| **PROFESSIONAL FEE/S** | |  | |  | |  | |  | |  | |  | |  |  |
| **1 . JONATHAN P. LUSECO, MD** | |  | |  | |  | |  | | **PHP 390.00** | |  | |  |  |
| **2** | |  | |  | |  | |  | |  | |  | |  |  |
| **SUB TOTAL** | | **PHP 4400.00** | | **N/A** | | **N/A** | | **N/A** | | **PHP 3900.00** | | **N/A** | | **PHP\_\_\_\_\_\_\_\_.00** |  |
| **TOTAL**  ${vaccinator} | | **PHP 4400.00** | | **N/A** | | **N/A** | | **N/A** | | **PHP 3900.00** | | **N/A** | | **PHP\_\_\_\_\_\_\_\_.00** |  |
| **PREPARED BY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CONFORME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  ${name\_formal} | | | | | | | | | | | | | | | |
| **BILLING CLERK / ACCOUNTANT MEMBER/ PATIENT/ AUTHORIZED REPRESENTATIVE** | | | | | | | | | | | | | | | |
| **( SIGNATURE OVER PRINTED NAME ) ( SIGNATURE OVER PRINTED NAME )**  ${d0\_date} | | | | | | | | | | | | | | | |
| **DATE SIGNED :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RELATIONSHIP TO MEMBER OF AUTHORIZED REPRESENTATIVE:** | | | | | | | | | | | | | | | |
| **CONTACT NO.: ${vacc\_contact} \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  ${d0\_date}  ${patient\_contact} | | | | | | | | | | | | | | | |
| **DATE SIGNED:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CONTACT NO.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | | | | | |
| **REMARKS : (${c1}) NO BALANCE BILLING FOR (${c2}) INDIGENT (${c3})SENIOR (${c4}) NHTS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | | | | | |
| **NOTE: 1. FILL OUT FORM LEGIBLY 2. THE MEMBER/ PATIENT/ AUTHORIZED REPRESENTATIVE SHOULD NOT SIGN A BLANK SOA.** | | | | | | | | | | | | | | | |
| **3.PRINTED COPY OF SOA OR ITS EQUIVALENT SHOULD BE FEE OF CHARGED** | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |