

BF 32320

Private & Confidential 私人及保密文件

醫療索償表格

Medical Claim Form

(Applicable for Hospitalization &/or Surgical Medical, Hospital Cash, Surgical Cash, Critical Illness type of General Insurance)
(適用於住院及/或手術醫療、住院現金、手術現金及危疾種類之一般保險保障)

Scanned

30 NOV 2017

GI Claims



ZURICH®

蘇黎世

CLM-Original
Highly Confidential

為協助本公司處理您的索償申請，請於收到此表格後30日內，將此表格與原收據一併寄回本公司。
In order to assist us in processing your claim promptly, please complete and return this form together with the original receipts / receipts within 30 days after receiving the first.

Hospitalization &/or Surgical Medical, Hospital Cash, Surgical Cash, Critical Illness Insurance. Please call 2903 9388 for enquiry or fax to 2968 1660.
住院及/或手術醫療、住院現金、手術現金及危疾保障。任何查詢，請致電 2903 9388 或傳真致 2968 1660。

所有問題均須由受保人或其監護人作答

All questions must be answered by insured person or the guardian

保單號碼

Policy no.

HPS0018004ZC ✓

保戶姓名

Name of insured

病人姓名

Name of patient

地址

Addr

身份

Identity card no.

病人職業

Occupation of patient

SHOP MANAGER

與保戶關係

Relationship with insured

Spouse

電郵地址

Email address

聯絡電話及傳真號碼

Telephone & facsimile no.

Details of the hospitalization / clinic surgery

(a) 醫院 / 診所名稱

Name of hospital / clinic

ST. PAUL'S HOSPITAL

(b) 入院 / 門診手術日期

Date of admission / clinic surgery

20-11-2017

(c) 主診醫生姓名

Name of the attending doctor(s)

DR. T. L. CHAN

Are you making any other insurance or compensation claim as a result of this incident?

否 No

() 是 Yes

若是，請提供以下資料 If yes, please provide the information below

保單號碼

Policy no.

保險公司名稱

Name of insurance company

保障類別 (如：醫療費用 / 住院現金)

Type of insurance (e.g. medical expenses / hospital cash)

若住院 / 門診手術係因疾病：

If hospitalization / clinic surgery was due to illness:

(a) 病人之病徵

Describe the patient's symptoms

RUB pain

(b) 入院 / 門診手術前多久此病徵才被發現

How long had the patient been having these symptoms before admission into hospital / clinic surgery

two days

(c) 請詳述

Give details of

日期

Date

醫生姓名地址及電話

Name(s), address(es) and telephone no(s)

(i) 此症之首位主診醫生

the doctor first consulted for this illness

20-11-2017

(ii) 轉介往醫院之醫生

the doctors who referred the patient to hospital

(iii) 診治病人之其他醫生

all other doctors consulted during this illness

(iv) 過去五年內所有醫生

all other doctors consulted during the past five years

CLM-29NOV17 16:15

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5. 意外 / 手術 (Accident / Surgery)

If hospitalization / clinic surgery was due to accident

(a) 意外何時發生

When did it happen

日期

Date: _____

時間

Time: _____

(b) 意外地點

Where did it happen _____

(c) 請述意外經過

Describe how it happened

(d) 請述受傷情況

Describe the injuries

(e) 曾到何警署報案

Police station to which the accident was reported _____

(f) 檔案編號

Police reference no. _____

6. 其他 (Others)

Others

索償程序完成後, 閣下是否需要退回已遞交之有關文件

I request to return the submitted claim document(s) upon completed the claim procedure

() 否 No

如是, 請選擇

(☒) 正本之醫療單據

(☒) 醫療報告

If yes, please tick () original medical receipts

() Medical report

索償文件

Claim documentation

請填妥本索償表並提交以下所需證明文件(正本), 如適用, 寄回本公司以便處理閣下之賠償事宜

Please complete and return this claim form together with the following documents (original copy), if appropriate, for our handling:

(1) 住院索償:

Hospitalization:

醫療賬單詳列:

Hospital statement showing:

各項費用, 病人姓名, 留院日期

Itemized charges, name of the patient, period of confinement

(2) 所有主診醫生/專科醫生/麻醉師/外科醫生/物理治療師之賬單詳列:

Receipt(s) of all attending doctors/specialists/anesthesiologist/surgeons/physiotherapists showing:

病人姓名, 求診日期, 診斷證明及/或治療紀錄, 醫療報告, 各項費用

Name of the patient, date of consultation, diagnosis and/or treatment given, medical report(s), amount charged

(3) 手術後/住院後之覆診費:

Post surgery / post hospitalization out-patient:

醫生賬單詳列:

Doctor's receipt showing:

病人姓名, 求診日期, 診斷證明及/或治療紀錄, 費用

Name of the patient, date of consultation, diagnosis and/or treatment given, amount charged

Private & Confidential 私人及保密文件

聲明及授權 Declaration and authorization

本人/吾等明白並同意以下有關 Zurich Insurance Company Ltd (「本公司」) 處理所收集及保存本人/吾等之個人資料的安排。

We understand and agree the following issues about the arrangement of my/our personal information collected or held by Zurich Insurance Company Ltd.

1. 由 Zurich Insurance Company Ltd (「本公司」) 收集或持有的客戶 (包括保單持有人、受保人、受益人、保費付款人、信託人、保單受讓人及索償人) 個人資料, 均可供本公司使用作以下強制性用途, 以便為客戶提供服務 (否則本公司將無法為未能提供所需資料的客戶提供服務):
The personal information of customers (include policy owners, insured persons, beneficiaries, premium payors, trustees, policy assignees and claimants) collected or held by Zurich Insurance Company Ltd (「Company」) may be used by the Company for the following obligatory purposes necessary in providing services to the customers (otherwise the Company is unable to provide services to customers who fail to provide the required information):

- (1) 辦理、調查(及協助他人調查)和決定保險申請、保險索償及提供持續的保險服務;
to process, investigate (and assist others to investigate) and determine insurance applications, insurance claims and provide ongoing insurance services;
- (2) 辦理付款要求及直接付款授權;
to process requests for payment, and for direct debit authorization;
- (3) 處理任何對客戶的索償、訴訟及/或司法程序; 以及行使本公司的權利 (詳情見適用保單條款所定), 包括但不限於 代位權;
to manage any claim, action and/or proceedings brought against the customers, and to exercise the Company's rights as more particularly defined in applicable policy wording, including but not limited to the subrogation right;
- (4) 編撰統計數字, 或作會計及核算用途;
to compile statistics or use for accounting and actuarial purposes;
- (5) 符合對本公司及/或其所屬集團 (「蘇黎世保險集團」) 具約束力的任何本地或外國法例、規則、守則或指引的披露規定及如需要時進行核對程序;
to meet the disclosure requirements of any local or foreign law, regulations, codes or guidelines binding on the Company and/or its group (「Zurich Insurance Group」) and conduct matching procedures where necessary;
- (6) 遵循香港法院及監管機構作出的合法要求或指令, 包括但不限於保險業監理處、香港保險業協會、核數師、政府組織和政府相關機構;
to comply with the legitimate requests or orders of the courts of Hong Kong and regulators including but not limited to the Insurance Authority, Hong Kong Federation of Insurers, auditors, governmental bodies and government-related establishments;
- (7) 債務追討;
to collect debts;
- (8) 便利本公司的認可服務供應商, 就上述目的為本公司及/或客戶提供服務; 及
to facilitate the Company's authorized service providers to provide services to the Company and/or the customers for the above purposes; and
- (9) 使本公司的實際或建議承讓人能夠評核擬進行涉及有關轉讓的交易。
to enable an actual or proposed assignee of the Company to evaluate the transaction intended to be the subject of the assignment.

2. 本公司可就強制性用途, 向以下於香港境內或境外的人士提供任何客戶個人資料:

The Company may provide any personal information of customers to the following parties, within or outside of Hong Kong, for the obligatory purposes:-

- (1) 蘇黎世保險集團成員公司, 或任何進行保險或再保險相關業務的其他公司或中介人;
companies within the Zurich Insurance Group, or any other company carrying on insurance or reinsurance related business, or an intermediary;
- (2) 任何向蘇黎世保險集團提供行政、資訊、電腦、付款或其他與其業務運作有關的服務的代理人、承包商或第三方服務供應商;
any agent, contractor or third party service provider who provides administrative, telecommunications, computer, payment or other services to the Zurich Insurance Group in connection with the operation of its business;
- (3) 第三方服務供應商, 包括法律顧問、會計師、調查員、理賠師、再保公司、醫療及復康顧問、考察員、專家、維修人員、及資料處理者;
third party service providers including legal advisors, accountants, investigators, loss adjusters, reinsurers, medical and rehabilitation consultants, surveyors, specialists, repairers, and data processors;
- (4) 信貸諮詢機構, 而在客戶欠賬時, 任何債務追收代理或進行索償或調查服務的公司;
credit reference agencies, and, in the event of default, any debt collection agencies or companies carrying on claim or investigation services;
- (5) 根據對蘇黎世保險集團或其任何關連機構具約束力的任何法例, 及就任何由政府、監管或其他機關所頒佈且蘇黎世保險集團或其任何關連機構預期須遵守的任何規則、守則或指引而言, 蘇黎世保險集團有責任向其作出披露的任何人士;
any person to whom the Zurich Insurance Group is under an obligation to make disclosure under the requirements of any law binding on the Zurich Insurance Group or any of its associated companies and for the purposes of any regulations, codes or guidelines issued by governmental, regulatory or other authorities with which the Zurich Insurance Group or any of its associated companies are expected to comply;
- (6) 根據主管司法權區的法院的任何命令的任何人士; 及
any person pursuant to any order of a court of competent jurisdiction; and
- (7) 蘇黎世保險集團的任何實際或建議承讓人或蘇黎世保險集團對保單持有人的權利的受讓人。
any actual or proposed assignee of the Zurich Insurance Group or transferee of the Zurich Insurance Group's rights in respect of the policy owners;

3. 所有客戶均有權以書面向本公司之個人資料私隱主任 (地址如下) 要求查閱、修正及/或更改由本公司所持有有關其本身的任何個人資料。

All customers have the right to access to, correct, or change any of their own personal information held by the Company by request in writing to the Company's Personal Data Privacy Officer at the address below.

個人資料私隱主任
香港港島東華道18號
港島東中心26樓

Personal Data Privacy Officer
26/F, One Island East
18 Westlands Road
Island East
Hong Kong

4. 根據私隱條例, 本公司有權收取合理費用, 藉以處理任何資料的查閱要求。
In accordance with the Ordinance, the Company has the right to charge a reasonable fee for processing any data access request.

5. 本通知的中英文版本如有任何歧異或不一致, 概以英文版為準。
In the event of any discrepancy or inconsistencies between the English and Chinese versions of this notice, the English version shall prevail.

Private & Confidential 私人及保密文件

本人/吾等謹此聲明，以上所填報之資料及所列各項之事件乃屬完全真確並無對保險公司作任何資料之保留。
I/We declare that the answers given above are true and complete to the best of my knowledge and belief.

本人/吾等授權任何僱主、醫院、醫生、醫務人員、保險公司等任何有關人士或組織而持有本人/吾等有關意外、身體狀況和醫療紀錄等資料，可以將該等資料提供貴公司或其代理人，此授權書之影印本亦屬有效。

I/We hereby authorize any employers, hospital, physician, insurance company or other organization or person who has any records or knowledge with reference to the accident or the health and medical history of the patient, to give such information to Zurich Insurance Company Ltd or its agents. A photocopy of this authorization shall be considered as effective and valid as the original.

為符合個人資料(私隱)條例，從以下簽署，本人/吾等同意由蘇黎世保險有限公司或其代理人所收集或持有的個人資料包括使用本人之身份證明文件副本，不論包含在這報告表或以其他方式獲取，均可供貴公司使用或向在香港境內或境外之任何人或機構披露作其保險或再保有關事項包括處理索償、調查、收集客戶資料和訴訟。

By signing below, I/We, for the purpose of the Personal Data (Privacy) Ordinance, agree that the personal information collected or held by Zurich Insurance Company Ltd (whether contained in this form or otherwise obtained) or its agents to utilize the copy of my identification or may be used by or disclosed to any individual or organization within or outside of Hong Kong for the purposes of insurance or reinsurance related business including claim processing, investigation, account collection and litigation.

如中文譯本與英文原文有異，概以英文文本為準。

保單持有人簽署 Signature of policy holder

病人(受保人)簽署 Signature of patient

日期 Date

2017-11-28

保單持有人姓名 Name of policy holder

病人(受保人)姓名 Name of patient

香港身分證號碼
或護照號碼 Passport no

香港身份證號碼 HKID Card no /
或護照號碼 Passport no

Private & Confidential 私人及保密文件

由主診醫生填寫，有關費用由索償者支付

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To be completed by the attending physician / surgeon at the claimant's own expense

Please complete in block letters

Name of patient	identity card no
Date of admission	Date of discharge
Name of hospital or clinic	

20/11/2017 St. Paul's Hospital 27/11/2017

(1) Clinical history of this patient:

(a) Date on which the patient first consulted you relating to this medical condition(s)/injury 26/11/2017

(b) If caused by injury, please describe the cause and extent of injury

(c) Symptoms and complaints for this hospitalization/treatment RUQ pain

(d) Underlying cause(s) of the hospitalization or operation acute cholecystitis with gall stones

(e) According to the medical history given by the patient, how long had he/she been experiencing these symptoms before the first consultation and the date of the first consultation? 2 days

(f) How long, in your opinion, has the patient been suffering from this illness/injury? 2 days

(g) Was the patient confined in an Intensive Care Unit during this hospitalization or did he/she suffer from 3rd or 4th degree of burning? If yes, please indicate the period/numbers of days stayed no

(2) Hospitalization or operation history of this patient:

(a) Final diagnosis ① CBD stone ② gall stones, causing acute cholecystitis

(b) Date of operation ① ERCP on 21/11/2017 ② laparoscopic cholecystectomy on 22/11/2017

Operational procedure(s) performed

(c) If you have consulted other doctor during this hospitalization or operation, please provide the following:

Consulted doctor's name Dr. Lee Siu Wang Reason for question (1) & (2)

What treatment(s) had the doctor performed ① ERCP ② LC

(d) Please give brief discharge summary (including onset and duration of signs and symptoms/disease, etiology, types and results of major examination, treatment, complications and follow up plan) Gall stone which has passed into CBD and required ERCP. Gall stone also caused acute cholecystitis with severe emergency LC.

(e) Has the patient taken any home leave during this hospitalization? If yes, please state the date, time and reason no

(f) Please provide reason(s) for hospitalization if this type of cases can be managed on day care cannot. Operation facilities only in hospital.

(3) Professional comment:

(a) In your opinion, was the hospitalized or treated illness a recurrent episode or a chronic illness or related to a previous complaint/diagnosis? If yes, please provide date of the first episode and details no

(b) Has the patient ever had the same symptoms before/has the patient been treated or hospitalized for these same symptoms before? no

If yes, please state, to the best of your knowledge, on a separate sheet when and describe details (including a brief summary describing the onset date, duration of signs and symptoms, disease, etiology, types and results of major examination, treatments, complications and follow up plan)

(c) Was the condition due to or associated with the following (please circle the right answers)?

Accidental bodily injury, abuse of drugs or alcohol, AIDS / HIV related illness, venereal disease or sexually transmitted disease, pregnancy, childbirth, miscarriage, abortion, infertility or sterilization, correction of vision, refractive error, cosmetic or plastic surgery, mental or nervous disorder, congenital condition hereditary condition, developmental condition, suicide, attempted suicide, ionizing radiation, self-inflicted injury, participation in any sports, general check up or vaccination or none of the above

(e) If you are referred by another doctor, please provide the referring doctor's full name and address

I hereby certify that all information given above is accurate and true to the best of my knowledge

Dr. H.K. Fung, FRCS, FHKAM

Name of attending doctor / surgeon / qualification

27/11/2017

Date

Country Hospital Building 410 King Rd. No. H.K.

Address and telephone no

ST. PAUL'S HOSPITAL
FOR INSURANCE
CLAIM FORM ONLY

Print Date : 27-11-2017

Time 09:56

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出院結算單

Discharge Statement

學師全覽

HOSPITAL NO. : HN20170336900

因未得胜

BED NO. B1307D

這人姓名

PATIENT NAME :

主治醫師

ATTENDING DR. : DR. _____

人際交往的困難

出器宗則皮時型

ADM./REG. DATE & TIME : 20-11-2017 11:07

DISCHARGE DATE & TIME : 27-11-2017 09:43

(A) Invoice Summary 賬單概覽

Invoice Date 賬單日期	Invoice No. 賬單號碼	Invoice Amount 賬單數目(HK\$)	Total Paid Amount 已付總額(HK\$)	Outstanding Amount 未結金額(HK\$)
23-11-2017	AC2017052278	60,898.00	60,898.00	0.00
27-11-2017	AC2017052839	77,719.00	77,719.00	0.00
	Total 總數	138,617.00	138,617.00	0.00

(B) Payment Summary 付款概覽

Payment Date 付款日期	Payment Method 付款方法	Paid Amount 已付金額(HK\$)	Invoice No. 賬單號碼
20-11-2017	MASTERCARD	10,000.00	AC2017052839
27-11-2017	MASTERCARD	60,898.00	AC2017052278
27-11-2017	MASTERCARD	77,719.00	AC2017052839
	Total 總數	148,617.00	

(C) Down Payment Summary 按金概覽

Receipt Date 接收日期	Document No. 文件號碼	Amount 金額(HK\$)	Payment Method 付款方法	Deducted Amount 扣除金額(HK\$)	Balance Amount 結餘金額(HK\$)
20-11-2017	DR20171101901	10,000.00	MASTERCARD	10,000.00	0.00
	Total 總數	10,000.00		10,000.00	0.00

(D) Outstanding Balance 結餘

Outstanding Invoice 未結賬單 (A)	0.00
Down Payment Balance 按金結餘 (C)	0.00
Net Amount 餘額	0.00

(E) Invoice Summary by Items 帳單項目概覽

Invoice Item 項目	Amount 金額(HK\$)
DIAGNOSTIC & INTERVENTIONAL RADIOLOGY MATERIAL COS*	620.00
DOCTOR FEE	81,400.00
ENDOSCOPY	3,800.00
ENDOSCOPY MATERIAL COST*	4,340.00

2901

相對於「隱形城市」之「數個新點」，「自由」，「自治」，「平等」。

2. 按《保留和檢閱》(3)收取須知, 將已交之摺款。

Remarks:

1. Should any discrepancies arise between this Statement and Invoice, please contact Accounts Department for clarification

2. Hospital reserves the right to impose surcharge on the overdue accounts.

[ACRPT601]

St. Paul's Hospital

Print Date : 27-11-2017

Time : 09:56

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**出院結算單
Discharge Statement**

住院編號

HOSPITAL NO. : HN20170336900

病床編號

BED NO. : B1307D

病人姓名

PATIENT NAME :

主診 醫生

ATTENDING DR. : DR. [REDACTED]

入院/登記日期及時間

ADM./REG. DATE & TIME : 20-11-2017 11:07

出院日期及時間

DISCHARGE DATE & TIME : 27-11-2017 09:43

ENDOSCOPY-MEDICATION	2,559.00
HISTOPATHOLOGICAL EXAMINATION	1,500.00
LABORATORY	2,455.00
MEAL/BEVERAGE CHARGES	410.00
MEDICATION FEE	10,093.00
MRI	5,040.00
OPERATING THEATRE CHARGES	9,634.00
OPERATING THEATRE MATERIAL COST	11,674.00
OPERATING THEATRE-MEDICATION	5,961.00
ROOM CHARGE	5,950.00
TREATMENT/ASSOCIATE MATERIALS	2,021.00
X RAY FLUOROSCOPY & CONTRAST STUDY	1,160.00
Total 總數	148,617.00

備註:

1. 如以此結算單所列之數額與賬單上有所不同，請與會計部聯絡
2. 本院保留向逾期賬目收取附加利息之權利

Remarks:

1. Should any discrepancies arise between this Statement and Invoice, please contact Accounts Department for clarification
2. Hospital reserves the right to impose surcharge on the overdue accounts.



聖保祿醫院
St. Paul's Hospital

(Incorporated in Hong Kong and limited by guarantee)

2 Eastern Hospital Road, Causeway Bay, Hong Kong
Tel: 25906008 Fax: 25964558

CLM-Original

Medical Certificate

醫生證明書

This is to certify the below named patient 茲證明下列病人：

(Please tick as appropriate 請在適當之方格內加「✓」號)

☒ has attended this hospital on

於

在本院診治。

☒ has been an in-patient from

於

26/11/2017 to 27/11/2017

本院住院病人。

☒ is suffering from

因患上

Jaice Huns + CBP Huns. Operation Done.

☒ is recommended for sick leave from

建議給予病假

26/11/2017 to

to

27/11/2017

inclusive.

止。

☒ is required to follow up on

並須於

30/11/2017

覆診。

☒ is advised to avoid heavy physical duty for

day(s) from the date of this certificate.

建議由本證明書簽發起計

日避免體力勞動之粗重工作。

Remarks (if any) 備註(如適用)：

Doctor's Signature 醫生簽名：

Doctor's Name (BLOCK LETTER) 醫生姓名：

Date 日期：

27/11/2017

PN2017081271
Ward: B1307D
Sex: M
Age: 49Yr6M (2017)
Class: C
20-11-2017 11:07:16
PN20170801271



Hospital Chop 醫院印鑑：

CLM-Original

聖保祿醫院

St. Paul's Hospital

香港新界東區沙田

2 EASTERN HOSPITAL ROAD, HONG KONG

Tel: 2350 0098

Website: www.stpaul.hk

收 費 單

STATEMENT OF ACCOUNT

2 of 2

AC2017052839

Male

B1307D

25-Nov-2017

HN20170336900

20-Nov-2017

27-Nov-2017

日期 DATE	項 目 PARTICULARS	金額 AMOUNT (HK\$)	總金額 SUB-TOTAL (HK\$)
	Anaesthetic 麻醉費	\$8,000	\$8,000
25-11-17	52244 DR. 手術費 Operation	\$42,000	\$42,000
26-11-17	52120 DR. 巡房費 Ward Round Fee	\$900	\$900
27-11-17	90102 DR. 巡房費 Ward Round Fee	\$4,500	\$4,500
	手術費 Operation	\$20,000	\$24,500
	TOTAL DOCTOR FEE (\$)		\$81,400
	醫生費合共		\$81,400
	GRAND TOTAL 總額		\$87,719
	Less: In-Patient Deposit 減: 已繳按金		-\$10,000
	TOTAL BALANCE DUE 應繳金額總數		\$77,719

ST. PAUL'S HOSPITAL
ACCOUNTS OFFICE
RECEIVED PAYMENT
WITH THANKS

Payment Date: 27-Nov-2017

MASTERCARD \$77,719

Total: \$77,719

N. B.

1. The patient's account must be settled every 3 days, full settlement must be made before discharge. Deposit will be offset in the final account.
2. Outpatient account must be settled after consultation.
3. Receipt is only valid when hospital stamp is imprinted. No other official receipt will be issued.
4. Additional administrative charges will be levied for reissuing statements.
5. The Hospital has the rights to levy overdue charges.
6. Patients are obliged to settle any undercharge.

E & O. E.

CLM-Original

聖保祿醫院

St. Paul's Hospital

2 EASTERN HOSPITAL ROAD, HONG KONG

TEL: 2656 6106

Website: www.stpaul.org.hk

收 費 單

STATEMENT OF ACCOUNT

1 of 2

27-Nov-2017

AC2017052839

Male

PATIENT NO. HN20170336900

ROOM NO. B1307D

ADMISSION DATE 20-Nov-2017

DISCHARGE DATE 27-Nov-2017

日期 DATE	項 目 PARTICULARS	金額 AMOUNT (HK\$)	總金額 SUB-TOTAL (HK\$)
23-11-17	MEDICATION FEE 藥費	\$377	
	ROOM CHARGE 房租	\$850	
	TREATMENT/ASSOCIATE MATERIALS 治療及有關物料費用	\$449	\$922
24-11-17	LABORATORY 化驗費	\$665	
	MEAL/BEVERAGE CHARGES 餐飲服務費用	\$20	
	MEDICATION FEE 藥費	\$499	
	ROOM CHARGE 房租	\$850	
	TREATMENT/ASSOCIATE MATERIALS 治療及有關物料費用	\$409	\$2,444
25-11-17	MEAL/BEVERAGE CHARGES 餐飲服務費用	\$25	
	MEDICATION FEE 藥費	\$449	
	ROOM CHARGE 房租	\$850	
	TREATMENT/ASSOCIATE MATERIALS 治療及有關物料費用	\$299	\$1,623
26-11-17	MEAL/BEVERAGE CHARGES 餐飲服務費用	\$130	
	MEDICATION FEE 藥費	\$276	
	ROOM CHARGE 房租	\$850	\$1,306
27-11-17	TREATMENT/ASSOCIATE MATERIALS 治療及有關物料費用	\$24	\$24
	TOTAL HOSPITAL CHARGES 醫院費合共		\$6,319
28-11-17	DR. [Name] 麻醉費	\$6,000	\$6,000
22-11-17			



N.B.

1. This statement is for information only. It does not constitute an offer of insurance or any other financial product. Please refer to the actual policy for details.

2. Disputes should be raised with the patient's insurance company.

3. Receipts issued by the hospital are for information only. They are not to be used for insurance claims.

4. Receipts issued by the hospital are for information only. They are not to be used for insurance claims.

5. The hospital has the right to refuse to issue receipts.

6. Patients are asked to settle any outstanding bills.

E. & O. E.

CLM-Original

聖保祿醫院

St. Paul's Hospital

香港銅鑼灣醫院道2號

2 EASTERN HOSPITAL ROAD, HONG KONG

TEL: 2290 8008

Website: www.stpaul.org.hk

收費單

STATEMENT OF ACCOUNT

Page 2 of 2

AC2017052278

Male

B1307D

23-Nov-2017

HN20170336900

20-Nov-2017

27-Nov-2017

日期 DATE	項目 PARTICULARS	金額 AMOUNT (HK\$)	總金額 SUB-TOTAL (HK\$)
	TOTAL HOSPITAL CHARGES 醫院費合共		\$30,689
			\$60,898
	GRAND TOTAL 總額		\$60,898
	TOTAL BALANCE DUE 應繳金額總數		\$60,898



Payment Date: 27-Nov-2017

MASTERCARD \$60,898

Total: \$60,898

NOTES

1. This statement is prepared on the basis of the latest available information and is not intended to be a statement of account.
2. Any payment should be made to the hospital after the due date.
3. Hospital is not responsible for any loss or damage to any property or other items brought to the hospital.
4. All the information and charges will be subject to the hospital's records.
5. The hospital is not responsible for any loss or damage to any property or other items brought to the hospital.
6. Patients are requested to settle any account balance.

E. & O. E

CLM-Original

聖保祿醫院

St. Paul's Hospital

2 EASTERN HOSPITAL ROAD, HONG KONG

TEL : 2348 6008

Website: www.stpaul.org.hk

1 of 2

AC2017052278

Male

B1307D

-Nov-2017

Date 23-Nov-2017

NAME 1)

PATIENT NO. HN20170336900

ADMISSION DATE 20-Nov-2017

收費單
STATEMENT OF ACCOUNT

日期 DATE	項目 PARTICULARS	金額 AMOUNT (HK\$)	總金額 SUB-TOTAL (HK\$)
20-11-17	LABORATORY 化驗費	\$1,040	
	MRI 磁力共振	\$3,040	
	MEAL/BEVERAGE CHARGES 餐飲服務費用	\$125	
	MEDICATION FEE 藥費	\$4,593	
	ROOM CHARGE 房租	\$850	
	TREATMENT/ASSOCIATE MATERIALS 治療及有關物料費用	\$452	
			\$12,100
21-11-17	X RAY FLUOROSCOPY & CONTRAST STUDY X光透視及造影	\$1,160	
	DIAGNOSTIC & INTERVENTIONAL RADIOLOGY MATERIAL COST 診斷及介入放射物料費	\$620	
	ENDOSCOPY MATERIAL COST 內鏡中心物料費用	\$4,340	
	ENDOSCOPY-MEDICATION 內鏡中心藥費	\$2,559	
	LABORATORY 化驗費	\$375	
	MEAL/BEVERAGE CHARGES 餐飲服務費用	\$15	
	MEDICATION FEE 藥費	\$4,135	
	ENDOSCOPY 內鏡中心	\$3,800	
	ROOM CHARGE 房租	\$850	
	TREATMENT/ASSOCIATE MATERIALS 治療及有關物料費用	\$255	
			\$18,109
22-11-17	OPERATING THEATRE-MEDICATION 手術室藥費	\$3,961	
	HISTOPATHOLOGICAL EXAMINATION 病理組織化驗檢查	\$1,500	
	LABORATORY 化驗費	\$375	
	MEAL/BEVERAGE CHARGES 餐飲服務費用	\$35	
	MEDICATION FEE 藥費	\$527	
	OPERATING THEATRE CHARGES 手術室費用	\$9,634	
	OPERATING THEATRE MATERIAL COST 手術室物料費用	\$11,574	
	ROOM CHARGE 房租	\$850	
	TREATMENT/ASSOCIATE MATERIALS 治療及有關物料費用	\$133	

PAUL'S HOSPITAL
ACCOUNTS OFFICE
RECEIVED PAYMENT
WITH THANKS

- NOTE:
1. This statement is valid only if signed by the patient or the authorized person. It cannot be used as a receipt for payment.
 2. This statement is not valid if it is not signed by the patient or the authorized person.
 3. This statement is not valid if it is not signed by the patient or the authorized person.
 4. This statement is not valid if it is not signed by the patient or the authorized person.
 5. This statement is not valid if it is not signed by the patient or the authorized person.
 6. This statement is not valid if it is not signed by the patient or the authorized person.

E & O. E.

CLM-Original

聖保祿醫院
St. Paul's Hospital

HN20170226900 ST. PAUL'S HOSPITAL

Ward : B1307D



, Kong.

HKII

Dr.

Age : 49Yr6M (20)
Sex : M
Class : C
20-11-2017 11:07:16
PN20170801271

Date:

21/11/17

Patient's Name: _____

Room No.: _____

Doctor's Name: _____

Doctor Code: _____

Visit: _____ \$ _____

Special visit: _____ \$ _____

Operation: ERCP \$ 6,000

(Date)

(Date)

Anaesthetist: [Signature] \$ _____

(Name in block letter)

Consultant: _____ \$ _____

(Name in block letter)

Others: _____ \$ _____

Patient's copy

SPH No. **B 168634**



Total: \$ 6,000

Dr's signature: _____

* The Hospital is authorised to collect the fee on behalf of the doctors.

CLM-Original



聖保祿醫院
St. Paul's Hospital

(Incorporated in Hong Kong and limited by guarantee)

香港銅鑼灣東院道二號
2 Eastern Hospital Road, Causeway Bay, Hong Kong.

HN20170336900

ST. PAUL'S HOSPITAL

Ward B1307D



HKII

Dr.

20-11-2017 (11:07:16)

Sex: M

Age: 49Yr6M (20)

Class: C

20-11-2017 11:07:16

PN20170801271

26/11/2017

Patient's Name: _____

Room No.: _____

Doctor's Name: _____

Doctor Code: _____

Visit: 26/11/2017 \$ 900

Special visit: _____ \$ _____

Operation: _____ \$ _____

(Date)

(Date)

Anaesthetist: _____ \$ _____

(Name in block letter)

Consultant: _____ \$ _____

(Name in block letter)

Others: _____ \$ _____

Patient's copy



Total: \$ 900

SPH No. B 169755

Dr's signature: _____

* The Hospital is authorised to collect the fee on behalf of the doctors.

CLM-Original



聖保祿醫院
St. Paul's Hospital

(Incorporated in Hong Kong and limited by guarantee)

HN20170336900

Ward B1307D



Hong Kong.

HKID

Dr

Sex: M

Age: 49Yr6M (20)

Class: C

20-11-2017 11:07:16

PN20170801271

22 NOV 2017

Date: _____

Patient's Name: _____

Room No.: _____

Doctor's Name: _____

Doctor Code: 51010

Visit: _____ \$ _____

Special visit: _____ \$ _____

Operation: 22/11/17 GAX laparoscope \$ 8,000

(Date)

cholecystectomy

(Date)

Anaesthetist: _____ \$ _____

(Name in block letter)

Consultant: _____ \$ _____

(Name in block letter)

Others: _____ \$ _____

Patient's copy



Total: \$ 8,000

SPH No. B 167992

Dr's signature: _____

* The Hospital is authorised to collect the fee on behalf of the doctors.

CLM-Original



聖保祿醫院
St. Paul's Hospital

(Incorporated in Hong Kong and limited by guarantee)

香港銅鑼灣東院道二號
2 Eastern Hospital Road, Causeway Bay, Hong Kong.

醫生收費單
INVOICE - DOCTOR'S FEE *

Date: 25/11/2017

Patient's Name: _____

Room No.: _____

Doctor's Name: _____

Doctor Code: _____

Visit: 20/11 - 20/11 / 1st

Special visit: _____

Operation: ERECT SPHINCTEROMY (OP) \$ 1800

(Date)

Laparoscopic cholecystectomy \$ 24000

(Date)

Anaesthetist: _____ \$

(Name in block letter)

Consultant: _____ \$

(Name in block letter)

Others: _____ \$

Patient's copy

SPH No. B 161736

Dr's signature: _____

* The Hospital is authorised to collect the fee on behalf of the doctors.



Total: \$ 42000

(Incorporated in Hong Kong and limited by guarantee)

CLM-Original

INVOICE - DOCTOR'S FEE *

27/11/2017

Room No.:

Doctor Code:

Visit: 20/11/2017, 22/11/2017 to 24/11/2017, 27/11/2017

$$\begin{array}{r} 900 \times 5 \\ \hline = 4500 \end{array}$$

Operation:

(Date _____)

(Date)

Anaesthetist:

(Name in block letter)

Consultant :

(Name in block letter)

Others:

Patient's copy

SPH No. **B 169767**

Dr's signature :

* The Hospital is authorised to collect the fee on behalf of the doctors.

