



**FINANCIAL COUNSELLING FORM**  
**Agreement for Hospital Services**

**ADMISSION DETAILS**

<b>Specialty</b>	<b>Admitting Doctor</b>		
<b>Surgical Procedure/Operation (Operation Table/Code)</b>	SA700B	<b>Admission Date</b>	03/02/2026
<b>Expected Length of Stay</b>	1	<b>Admission Time</b>	13:55
<b>Patient Name</b>		<b>Room Type</b>	Cardiovascular Suite

**ESTIMATED DOCTOR(S)' FEES (EXCLUDES GST)**

<b>Consultation Fee(s)</b>	\$
<b>Procedure / Surgeon Fee(s)</b>	\$
<b>Assistant Surgeon Fee(s)</b>	\$
<b>Anaesthetist Fee(s)</b>	\$
<b>TOTAL ESTIMATED DOCTOR(S)' FEES</b>	\$ <b>N/A</b>

**ESTIMATED HOSPITAL CHARGES (EXCLUDES GST)**

<b>Accommodation Charges</b>			
Cardiovascular Suite (First 4 Hours)	\$ 165.14	\$	<b>165.14</b>
<b>Daily Treatment Fees</b>			
TREATMENT FEE-DAY SUITE	\$ 158.72	\$	<b>158.72</b>
<b>Ancillary* Charges</b>		\$	<b>2,740.00</b>
<i>*refers to estimated hospital facility fees, equipment fees, medications, laboratory tests, etc., excluding implants &amp; consumables</i>			
<b>Daily Companion Rate</b> (Daily Companion Room and Meal services charges apply)	\$		<b>0.00</b>
<b>TOTAL ESTIMATED HOSPITAL CHARGES</b>	\$		<b>3,063.86</b>

**TOTAL ESTIMATED CHARGES (EXCLUDES GST)**

<b>Total Estimated Doctors' Charges</b>	\$	<b>N/A</b>
<b>Total Estimated Hospital Charges</b>	\$	<b>3,063.86</b>
<b><sup>1</sup>Total Estimated Amount</b>	\$	<b>3,063.86</b>
<b><sup>2</sup>Estimated Medisave Claimable</b>	\$	<b>1,080.00</b>
<b><sup>3</sup>Deposit Required</b>	\$	<b>1,983.86</b>

<sup>4</sup>MOH Hospital Fee Benchmark

SA700B : Not Available

The Hospital will collect 100% of the Total Estimated Amount for Self-Payors.

<sup>4</sup>Please refer to <https://www.moh.gov.sg/managing-expenses/bills-and-fee-benchmarks> for more information.

**1 Total Estimated Amount**

1. The undersigned requests that the Hospital provides to the patient any hospital (including, but not limited to, hospitalisation) and other services to the patient as may be requested by the patient or as may be appropriate or necessary in respect of the patient's physical and mental health or care.
2. The undersigned agrees and understands that:-
  - (1) the provisional diagnosis/code referred to above may only set out the patient's treating doctor(s)'s preliminary views of the patient's medical condition, and may not represent the patient's final diagnosis or actual condition for which hospital and other services are rendered by the Hospital;
  - (2) the estimated hospital charges, estimated doctors' fees, and estimated length of stay are only estimates and do not take into account any possible unforeseeable complication(s) or previously unknown medical condition(s) that may arise as a direct or indirect result of the diagnosis, treatment or management of the patient;
  - (3) no representation or warranty is made by the Hospital that the actual hospital charges or doctors' fees for hospital and other services provided to the patient will be limited to that which arises out of the provisional diagnosis/code or limited to the estimated hospital charges or estimated doctors' fees set out above;
  - (4) the estimated hospital charges and estimated doctors' fees exclude additional consignment items, surgical implants (including additional surgical implants that are needed or deemed required during the procedure as assessed by the treating doctors), histology charges and nuclear medicine;
  - (5) the actual hospital charges, doctors' fees, and other charges for all hospital and other services rendered by the Hospital, including any relevant other disbursements and expenses incurred, which are in relation to the patient and payable by the undersigned to the Hospital, may differ from the estimated charges and fees depending on the final diagnosis, the patient's medical condition, the actual length of stay in the Hospital, and actual treatment and management provided (including but not limited to the treatment and management of any complications that may arise or of any other condition that may be discovered during the patient's stay). No statement by any Hospital staff relating to the estimated total hospital charges, doctors' fees, and other charges for all hospital and other services rendered by the Hospital, including any relevant other disbursements and expenses incurred shall be construed as a representation to the undersigned or a term of this Agreement and any such statement shall not be binding on the Hospital unless set out in writing herein;
  - (6) the estimated doctors' fees and estimated length of stay have been provided by treating doctors who are not employees or agents of the Hospital, and the Hospital has no responsibility for the accuracy and/or appropriateness of the estimated doctors' fees or estimated length of stay quoted. The undersigned may obtain an estimate of the length of stay and doctors' fees (and or other charges by the doctor(s)) directly from the doctor(s) and/or their clinics, including their charges in the event of any complication(s) which may arise in the course of the diagnosis, treatment or management of the patient;
  - (7) any invoices rendered by the Hospital is final and conclusive between the Hospital and the undersigned, save that the Hospital reserves the right to amend any invoices rendered if they contain any manifest errors. The Hospital reserves the right to make changes to its pricing and pricing policies from time to time in its sole discretion; and
  - (8) the estimated doctors' fees and hospital charges are exclusive of Goods & Services Tax (GST). The undersigned shall be responsible for payment of GST (at the prevailing rates) that is imposed on all charges and fees invoiced by the Hospital to the undersigned.

**2 Estimated Medisave Claimable**

3. The Estimated Medisave Claimable is the estimated maximum amount that can be claimed from Medisave for hospital charges and doctor's fees. The actual Medisave claimable amount is subject to Medisave regulations and withdrawal limits, and the availability of Medisave funds. The Estimated Medisave Claimable is also dependent on patient's doctor(s)' classification of the patient's procedure under the Table of Surgical Procedures (TOSP), which is subject to audit by the CPF Board. If the audit results in a reduction of the amount of Medisave claimable, the undersigned shall be responsible to pay to the Hospital the difference arising from the reduced amount claimable from Medisave. A minimum of 8 hours is applicable for Medisave to be viable for inpatient admissions.

**3 Deposit Required**

4. At admission, the undersigned is to provide a deposit amounting to the **full** amount of the total estimated bill. In the following situations, the Hospital reserves its right(s) to collect an additional amount over and above the full amount of the total estimated bill as the deposit and the undersigned shall at the request of the Hospital provide the same immediately:-

- (1) For patients that are transferred from another hospital, or medically evacuated from overseas, an additional amount of S\$40,000.00 over and above the full amount of the total estimated bill for general wards and \$80,000 for ICU/ HDU/ CMZ or likewise is to be paid prior to admission;
  - (2) for patients who require biopsy and/ or pathology investigations to rule out malignancy, an additional deposit may be collected. This deposit collection is to facilitate additional investigation required to conclude the diagnosis by the testing laboratory. In the event the deposit is not utilised or partially utilised, the remaining amount will be reimbursed back to patient. Please note that additional payment will be required if the deposit collected is unable to fully cover the additional pathological investigation cost.
5. The undersigned agrees that if (i) the total outstanding invoices from the Hospital and/or (ii) the total unbilled hospital charges, doctors' fees, and other charges for all hospital and other services rendered by the Hospital (together the "**Liabilities**") exceed the amount that is deposited with the Hospital, the Hospital is entitled to apply the deposit(s) towards settlement of any or all the Liabilities and to require, and the undersigned agrees to provide, additional deposits from time to time. The quantum of the additional deposits shall be at the sole discretion of the Hospital.

### **Financial Obligation**

- 6. The undersigned shall pay the Hospital the amounts stated in any invoice issued by the Hospital immediately (the "**Invoiced Sum**"). For the avoidance of doubt, the undersigned's obligation to pay the Hospital shall not be limited in any way by the estimates of hospital charges or estimated doctors' fees set out above.
- 7. In the event that the undersigned fails to pay the Invoiced Sum in full when due, the Hospital reserves the right to charge to the undersigned:
  - (i) compound interest on the outstanding amounts on the Invoiced Sum from the date of the invoice at the Hospital's prevailing interest rate of 12% per annum, which may be amended by the Hospital in its sole and absolute discretion from time to time;
  - (ii) collecting agent's administrative fees, lawyers' fees, and experts' fees, and all disbursements and expenses incurred by the collecting agent, lawyers, and experts, on an indemnity basis.
- 8. Where a patient's doctor(s) involved in the treatment and management of the patient instructs the Hospital to assist such doctor(s) in the collection of the doctor(s)' charges (the "**Additional Doctor Charges**") from the patient and the Hospital purports to do so, the undersigned agrees that the Hospital shall have the right but not the obligation to apply any payments and deposits made by the undersigned towards settlement of the Invoiced Sum and the Additional Doctor Charges in such manner between them as the Hospital in its sole discretion deems fit.
- 9. Payment of any Invoiced Sum and Additional Doctor Charges can be made via cash, credit card, NETS, interbank GIRO or telegraphic transfer. Interbank GIRO and telegraphic transfer should be done in advance to allow the Hospital to receive the funds prior to admission and bank charges incurred shall be borne by the undersigned.
- 10. Payment of any Invoiced Sum and Additional Doctor Charges by way of cheque is not acceptable to the Hospital unless prior written approval for payment by way of cheque has been indicated by the Hospital.

### **Technical Discharge**

- 11. The Hospital may, from time-to-time, issue one or more invoice(s) for the hospital services and facilities rendered to the patient. If the patient is not discharged at the time of the issuance of an invoice, the Hospital may issue a new Case No. to the patient with the "Admission Date" reflecting the date the new invoice is issued. In such event, this Agreement shall continue to bind the undersigned and have full force and effect. The undersigned shall pay all Invoiced Sums to the Hospital and/or to fully settle all invoices rendered by the Hospital.

### **Discharge**

- 12. The undersigned must settle all Invoiced Sum(s) in full at point of discharge. Interim invoices may be provided by the Hospital from time to time as deemed appropriate by the Hospital. An itemised invoice shall be provided by the Hospital to the undersigned / patient upon the undersigned's / patient's request respectively.
- 13. The undersigned agrees that the Hospital is entitled to discharge the patient from the Hospital or transfer the patient from the Hospital to another hospital if the undersigned fails to pay the Invoiced Sum(s) in full when due and/or if the undersigned fails to provide any deposit(s) as required by the Hospital. For the avoidance of doubt, the Hospital's rights to claim and/or recover any Invoiced Sum(s) is not affected or prejudiced by such discharge or transfer.

## **Refund**

14. The undersigned further authorises the Hospital to apply any excess funds of the undersigned after payments in full of the Invoiced Sums towards any other amounts that may be owed by the undersigned or the patient to the Hospital, whether related to the current admission or otherwise.
15. In the event that there are still excess funds remaining with the Hospital, the Hospital shall process the funds according to its refund policy. The Credit Card Payment and Refund Authorization Form must be completed if you wish to request for specific refund instruction. By completing the CC-PRAF, the undersigned unconditionally authorises the Hospital to refund the excess funds to the undersigned at any time as the Hospital deems fit and payment thereof by the Hospital shall constitute a full and valid discharge of its obligations to the undersigned. The authorisation shall remain valid and effective until and unless revoked by notice in writing to the Hospital by the undersigned.

## **Entire Agreement**

16. This agreement contains the entire agreement between the Hospital and the undersigned with respect to the terms of the provision of hospital and other services to the patient. In this regard, any statements or representation by any person (including any staff of the Hospital or doctors) as regards any matters set out in this agreement shall not be construed as a representation to the undersigned or a term of this Agreement and any such statement shall not be binding on the Hospital unless set out in writing herein. The undersigned agrees that the undersigned has not relied on any such statements or representations.

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## **PATIENT ACKNOWLEDGEMENT**

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17. I confirm that the Hospital has fully explained the above to me and I have understood and fully agree to the above. Where the English language is not used, an oral translation of the above has been provided to me and I have understood the translation conveyed to me.
18. My appointed representative shall only act on my behalf during the period of my hospitalisation at the Hospital and until the Invoiced Sum(s) have been fully paid to the Hospital.
19. I acknowledge that I fully understand that the estimations may differ from the actual charges for the abovementioned reasons as stated above and as explained to me. Where necessary, I authorise my appointed representative to approach the Hospital's Business Office and the doctors' clinic for a revised estimate.
20. I understand and agree that the Hospital may collect from me on the doctors' behalf all fees and charges that are charged by the doctors involved in my treatment and management.
21. I consent to have my appointed representative top up the deposit during my hospitalisation should the Invoiced Sum(s) exceed that of my initial deposit. I am fully aware that the Hospital may contact my appointed representative from time to time to update him/her on my hospital charges, doctors' fees, and other charges for services under this agreement.
22. I warrant and undertake to the Hospital that:
  - (1) I am not bankrupt or insolvent;
  - (2) I am not subject to any bankruptcy, insolvency or other similar proceedings in any jurisdiction;
  - (3) no receiver or trustee has been appointed in respect of all or any substantial part of my assets; and
  - (4) I have not entered into any composition or arrangement with my creditors.
23. Where applicable, I shall provide to the Hospital a Letter of Guarantee (LOG) and/or Medical Benefits Card and relevant supporting documents from my insurance provider / employer prior to my admission. I am aware that where my insurance provider / employer does not have any credit facility with FPH, I am required to pay a deposit and settle the hospital bill in full upon discharge. For Singaporeans and Permanent Residents, I am also aware that a Medishield Life and/or Medisave-Approved Integrated Shield Plan (ISP) shall not constitute a waiver of deposit and payment.
24. I understand that for any reason whatsoever, should my selected ward-type be unavailable, the Hospital will provide an alternative ward-type subject to availability. I also authorise the Hospital to transfer me to my preferred ward-type once it becomes available. Should I choose to remain in the alternative ward-type, I agree to bear all ward charges that are applicable.
25. During my stay, I agree that my personal valuables ("Valuables") handed over to the Hospital for safekeeping in the Hospital is done at my own risk. I will not hold the Hospital liable for any loss or damage to the Valuables. In the event that I or my appointed representative do not claim the Valuables from the Hospital within 30 days from

the date of my discharge, the Hospital will deem the Valuables as unclaimed property and I authorise the Hospital to make arrangements for their disposal as the Hospital deems fit.

26. I agree that I will be liable for the cost of repair or replacement of hospital property which is damaged or lost by the patient or by my relatives, friends and/ or visitors.
27. I agree and understand that the Hospital will levy a surcharge in accordance with the prevailing rates for services rendered outside the office hours of the Hospital's respective departments.
28. I understand that the discharge procedure may commence from 10.00 am and if I decide to be discharged at any time after 12 pm, the Hospital will charge an additional half-day's or full day's charges (after 6pm) for my ward stay and fees for daily treatment(s) without pro-ration.
29. I may receive visitors from 12.00 pm to 8.00 pm daily during my stay in the Hospital and shall ensure that they conduct themselves in a considerate manner.
30. I hereby authorise and consent for admission to the Hospital for diagnostic procedures, medical, surgical and/or other treatment of my medical condition (including any complications that may arise), the release and disclosure of all or any of my medical records, bills and such other documents and/ or information as may reveal the nature of treatment extended to me and/or my medical condition or otherwise (i) as required by law; (ii) to the Ministry of Health or any other relevant government authority; (iii) such person(s) that may require the same to facilitate the performance of any required Medisave audit activity or any other audit or review sanctioned by the Hospital's Medical Board and/or Administration; and (iv) to the Hospital's agent(s), contractor(s), sub-contractor(s), staff and medical practitioners accredited to practise at the Hospital for and in relation to the services rendered under this agreement, who may all access and/ or use any of the information.
31. I hereby authorise the collection, use, disclosure and/or processing of all or any of my/ the patient's personal data, medical information, information, medical records and other records for purposes reasonably required by the Hospital, their representatives, agents and / or business partners to enable them to provide the patient with medical treatment and any other purposes set out in more details in the Hospital's Personal Data Protection Policy found at the Hospital's website or available upon my request (which may be amended from time to time in the Hospital's sole and absolute discretion) including to the patient's insurance provider for the processing of patient's insurance claims for the hospital and other services and for enforcement of the Hospital's rights.
32. In giving my consent, I confirm that the Hospital has explained to me and I have understood its Personal Data Protection Policy. I am also fully aware that I can withdraw my consent by giving reasonable notice to the Hospital and am fully aware of the consequences of withdrawal of such consent.

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Signature/Thumbprint & Date, Patient Name, NRIC/FIN/PP Number (or affix sticky label with Patient's acknowledgement)  
*If patient is unable to sign the above, the undersigned warrants that he/she has the patient's authority to accept the above terms and conditions on behalf of the patient and does accept all the above terms and conditions on the patient's behalf, as follows:*

State reason of Patient's inability to acknowledge: \_\_\_\_\_  
Agreement by \*Parent/Spouse/Child/Guardian/Legal Representative/ Next-of-Kin (\*circle where applicable)

If Next-of-Kin, state relationship with Patient: \_\_\_\_\_

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Full Name (Block Letters), NRIC/FIN/PP No., Signature/Thumbprint & Date and Address  
(Staff to acknowledge with Name/ Chop & Date stamp)

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**UNDERTAKING (PERSON OTHER THAN PATIENT)**

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In consideration of your admitting and/or rendering hospital services/facilities to the patient at my request, I hereby declare that I am not an undischarged bankrupt and agree to all the terms in sections 1 to 32 above and undertake to be liable and/or jointly and severally liable with the patient to pay the Hospital the Invoiced Sum(s) and to be similarly liable for any interest chargeable and/or collecting agents' fees, lawyers' fees, experts' fees and other disbursements and expenses as set out above.

I confirm that this undertaking shall not be limited in anyway by the estimated hospital charges, estimated doctors' fees, and other estimated charges (if any) above and I confirm that I am liable to pay the Invoiced Sum(s) to the Hospital forthwith upon the issuance by the Hospital of any invoice based on the final diagnosis, the patient's medical condition(s), actual treatment or services/facilities provided (including but not limited to the diagnosis, treatment or management of any complication(s), whether foreseeable or not and howsoever caused), and the actual length of stay in the Hospital, interest and/or collecting agents' fees, lawyers' fees, experts' fees and disbursements and expenses as set out above, without any legal set-off, equitable set-off or counterclaim.

For accounting purposes, if the patient is not discharged at the time of the issuance of an invoice, the Hospital may issue a new Case No. to the patient and the "Admission Date" stated on the next invoice issued may not be the actual admission date of the patient. Notwithstanding the above, I confirm that this undertaking shall continue to bind me and that it shall be my continuing obligation to pay the Invoiced Sum(s) to the Hospital and/or to fully settle all invoices rendered by the Hospital.

I further confirm that my agreement hereunder is an independent obligation, several from any obligations of the patient, which shall continue in full force and effect notwithstanding that the patient or the person authorised by the patient to sign on his/her behalf (as the case may be) is unable or unavailable for whatever reason to sign this document.

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Full Name (Block Letters), NRIC/FIN/PP No., Signature/Thumbprint & Date and Address  
(Staff to acknowledge with Name/Chop & Date stamp)

Translated by the undersigned into \_\_\_\_\_ to \_\_\_\_\_  
(state language) (name(s) of the person(s))  
who confirms that he/she understands and agrees to the aforesaid terms and conditions.

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Translator's full Name (Block Letters), NRIC/FIN/PP No., Signature/Thumbprint & Date