Intellicare
YOUR INTELLIGENT HEALTH CHOICE

# Referral Control Sheet for Out-Patient Diagnostic Evaluation (RCS 2)

Loa No.: N2312S0005417

**VALID UNTIL:** 12/29/2023

| | | |
|---|---|---|
| Name of Patient : **MADELYN MAY DIONGZON** | ApCode : **AGK-122367-658** | RCS Date: **12/26/2023 12:00:00 AM** |
| Card Number: **1195-1400-0046-0689**<br>Account Number: **80-00-07392-00011-01**<br>Company: **SYMPH INC.**<br>Validity: **09/15/2023 TO 09/14/2024** | Hospital/Clinic: **HI-PRECISION DIAGNOSTIC CENTER - ANGELES BRANCH**<br>Birth Date: **01/26/1964**<br>Contract Age: **59**<br>Sex: **F** | |
| Inclusion:<br>Exclusion: **MMC; SLMC-QC; SLMC-GC; AHMC; CSMC** | PEC Limit: **125,000**<br>Max Limit: **125,000**<br>Room and Board: **REGULAR PRIVATE** | |
| Remarks:<br>Ph Required: **No** Covered up to _____ excess c/o patient. | Hospital Bill: _____<br>Professional Fee: _____ | |

**DEPARTMENT**

__Laboratory
__X-Ray
__Nuclear
__Ultrasound
__MRI/CT Scan
__Heart Station
__Rehabilation
✓ Others

| Diagnosis | Diagnostic Procedures Done | Special Instructions: |
|---|---|---|
| NEPHROLITHIASIS | KUB UTZ W/ PRE AND POST VOID | Covered up to excess c/o patient.<br><br>**RCS Remarks:** |

| Procedure Done By: | Anesthesia Done By: | Coordinator: |
|---|---|---|
| _____ | _____ | _____ |

**MADELYN MAY DIONGZON**
Parent/Member Printed Name and Signature

**ARLENE GUTIERREZ MACABAYA**
Requesting Physician/Coordinator's Name and Signature

**Kindly note that if you decide not to sign this document, INTELLICARE will not be able to process your requested transaction.**

**DATA PRIVACY CONSENT & WAIVER**

I, the undersigned, have read the foregoing statement and hereby express my consent to the above. I further understand (a) the reasons for the collection, processing, and disclosure of my Information and the ways in which said Information may be used, and I agree to said usage and disclosure; and that (b) it is my choice as to what information I provide and that withholding or falsifying information might act against the best interests of my assessment. I also acknowledge that the Company has and will always take commercially reasonable steps to protect and maintain the confidential nature of my personal information in accordance with its applicable privacy policies. I hereby affirm my right to be informed, object to processing, access and rectify, suspend or withdraw my information, and be indemnified in case of damages pursuant to the provisions of Philippine Data Privacy Law, other applicable laws, rules and regulations.

**OTHER UNDERTAKINGS**

I, likewise, acknowledge that all of the procedures indicated in this document had been done. I promise to pay for any procedure and professional fees not explicitly covered by the provisions of the Health Service /Group Corporate Agreement. Furthermore, by virtue of this undertaking, I hereby render the Company free from any liability on the collection of the acquired non-coverable charges (i.e. excess in limits, exclusions, etc.). I fully understand that in instances wherein payables were not settled upon availment, I will be subjected to credit documentation and will be charged of administrative fees as applicable.

MADELYN MAY DIONGZON — Name and Signature of Member

12/25/2023 9:52:39 PM — Date

HI-PRECISION DIAGNOSTIC CENTER - ANGELES BRANCH / ARLENE GUTIERREZ MACABAYA
Name of Hospital / Doctor

**Confidentiality Notice:** Intellicare will not disclose any information obtained in the conduct of the evaluation except as otherwise provided herein, subject to the provisions of the Data Privacy Act. Further, Intellicare guarantees that information that can be identified with you will remain confidential and will be disclosed only with your permission or as required by law.