medica

REQUEST FORM TO BE ACCEPTED AT medica

I the undersigned request to be accepted at medica for the purpose of performing surgery/medical treatment or other necessary medical procedures.

I request that the physicians, the nursing staff and all the employees employed by it or invited by it shall perform the necessary procedures and they shall give me any treatment required at their professional discretion pursuant to the circumstances of the matter.

I confirm that I have not been given any guarantee regarding the results of the treatment, the tests and the medical procedures that shall be given to me/to a patient at the medica, and I agree and I am aware that the treatments/the surgery at medica shall be performed by Prof./Dr.: _____ and whoever such shall be imposed upon pursuant to the existing procedures and guidelines in this Medical Center.

A. I am aware that the price determined for the cost of the procedure is not final and there could be various changes /additions if:
   1. The duration of the procedure shall exceed the allotted time period.
   2. The insurance cover that I received from the insurer is inconsistent with the procedure.
   3. There was a need to change the surgery and add an additional procedure and/or there was a need to add a device or implant which was not planned and was introduced due to a medical need and at the request of my surgeon.
   4. An additional laboratory/pathology test which was not planned in advance.
   5. At my request and/or there shall be a medical need to admit me overnight at medica.

B. For the purpose of covering the price supplement, if there shall be such, I deposit with medica a credit card voucher /blank check and I authorize medica to fill in the sum of the supplement as shall be determined by medica pursuant to the medica price list.

In the event that there shall not be a price supplement then medica shall return the voucher/check to me when I am discharged after completion of the procedure.

I am aware and I agree that no liability shall be placed on medica for any possessions, monies, jewellery or any other item of value.

I am aware that it is possible that the information transferred to medica by me and/or is received about me from any other source including information that is created or produced by medica in regard to the treatment and/or service provided to me, shall be recorded and saved by medica in its databases, pursuant to the terms of the Protection of Privacy Law 5741-1981. Such information is required for the objective of compliance with the provisions of any law including the provisions of the Rights of the Patient Law 5756-1996, and for the purpose and in regard to provision of the service provided by medica, and shall be transferred by medica to third parties solely and only for the aforementioned objectives subject to the provisions of any law.

I agree that the room number in the ward to which I shall be admitted shall be given to those who request such from the medica information desk or who shall request the information by telephone.

Patients signature: _____ Time: _____ Date: _____

Guardians signature: _____ Parents confirmation for a minor: _____

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