ADMISSION SLIP

PATIENT

Name ____________________

Age / DOB ____________ Sex ________

PH-ID ____________________

Date: __________

Person Admitting: Self / Relative / Friend

Name: ____________________

Phone No: __________ Email Id __________

TO BE COMPLETED BY DOCTOR {CONSULTANT / REGISTRAR}

Diagnosis / Reason For Admission ____________________

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Treatment Proposed Medical / Surgical ____________________

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Name Of The Primary Admitting Consultant ____________________

WARD: ☐ Single / Deluxe ☐ Super Deluxe ☐ Suite

☐ Multi Bed Ward ☐ 3 Bed Sharing ☐ 2 Bed Sharing

Expected number of days of stay in the hospital ____________________

Any Special Implants / Equipments / Medication Required ____________________

Insurance: Yes / No. TPA / Scheme ____________________

Corporate: Yes / No. Corporate ____________________

SELF PAY ☐ Running Bill ☐ Package Package Name ____________________

Cost Estimate ₹ __________ In words ____________________

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PRAKRIYA HOSPITALS
Nurturing Life

TERMS & CONDITIONS

1. The estimate provided is only an approximate figure for current treatment. If any treatment is required as a result of comorbid conditions / complications, further charges will be levied.
2. The hospital management will periodically update you regarding the medical conditions of the patients and its impact on the in-patient stay as well the bill amount.
3. Services not covered under Insurance / TPA / Corporate will be charged as per the actuals. If the insurance denies the claim, patient will be responsible to pay the pending due amount at the time of discharge.

Declaration (I owe you)

I have read and understood the information as well as the terms and conditions listed above. I hereby declare that I am willing to pay the charges according to the services provided during the hospital stay.

Name of the Patient / Relative / Friend ______________________

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Signature of the Patient / Relative / Friend

Name of the Witness ______________________

____
Signature of the Witness