# MODEL OF PAYMENT AND INFORMATION SHEET

ANADOLU
In Affiliation with
JOHNS HOPKINS MEDICINE

ÖZEL ANADOLU SAĞLIK MERKEZİ HASTANESİ

Date 18.05.2016

Dear Ivan Terziev ,

Thank you for selecting Anadolu Medical Center for your health care needs. I will be pleased to assist you during your visit to The Anadolu Medical Center to ensure that you receive the highest level of service at all times.
The information about requested appointments for your case are detailed on the following pages. Outlined below are a few notes about your pending visit.

**Appointment Confirmation Information**

1. Our office can assist with transportation and accommodation arrangements. While our transportation services from/to the airport are free of charge for our patients,
2. we also have negotiated special rates for patients of Anadolu Medical Center. Please let us know a head of time how we can assist you.
3. This I.P.T.P. Model of Payment and Information Sheet form should be returned to our office in order to confirm the appointment(s).
4. Bring copies of your passport, medical records (accepted only in English or Turkish) and any related radiological scannings to the appointment.
5. Please arrive to the International Services of Anadolu Medical Center 1 hour prior to your appointment time to complete the registration process, unless instructed otherwise. Anadolu Medical Center – International Services Department Phone number:
6. Notice of appointment cancellations must be provided at least 2 days prior to an appointment date or 4 days prior to a surgery or admission date.

**Finance**

1. All payments for medical services are expected before or on the first appointment date for self pay patients. You may either pay with a credit card, Money order or bank wire the funds. Directions on how to deposit funds are attached to this letter. During the treatment, care or recovery process, the final state of the bill will be checked with in reasonable timely intervals to verify if any extra payments are needed beyond the estimations given and the payments needed will be collected according to this verification.
2. For patients possessing International insurance, please contact your International Services
3. Coordinator to verify benefit eligibility and authorization for the visit when you receive this letter.
4. Any balance or credit remaining on your account at the moment of discharge will be debited or credited back to the bank account presented or the credit card number on file.
5. All deposits are based on an estimate only and we will be able to inform you of the final charges when the final bill is generated.
6. If the patient and relatives do not speak English, the interpreter demand (as daily translation or on-call translation) must be made by the patient/patient's family/legal representative of the patient to the International Services Department and the daily charges will be reflected to the invoice.
7. The responsibility of payment of the patient's transfer to another location by air travel or land ambulance in case of any need during or after the treatment process must be considered in advance and taken in charge by the patient/ legal representative of the patient.

Please contact the International Services Department for detailed information.

Sevil Tahir
International Services Department

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## AppointmentItinerary&EstimatedCost

| Visit Type | Department | Provider | Procedure | EstimatedCost |
|---|---|---|---|---|
| **Outpatient** | **Medical Oncology** | **Prof. Sedrar Truhal** | **The patient will make 7 cycles**<br><br>**9.300 – 9.800 TL**<br>**2.827 EUR – 2.979 EUR** by today's currency for **one cycle** | **65.100 – 68.600 TL**<br>**19.878 EUR – 20.851 EUR** by today's currency for 7 cycles |

- The need for further tests /appointment and the definitive course of treatment will be evaluated during the first appointment(s).
- The above referenced costs are **ESTIMATES** for the consultation/ test listed and are intended only as a guide to assist you in the preplanning your visit. The actual final charges may vary from initial estimated amount.
- These cost estimations do not cover any price changes due to any complications.
- Prices presented above as in currencies other than TL (Turkish Lira) might vary according to the daily changing exchange rates.

With the document here by, I,**……,**certify that I perfectly understand Anadolu Medical Center International Patient Services treatment planning and services policy and guarantee to make my payments according to Anadolu Medical Center payment procedure.

Last Name – First Name: Signature:

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**INTERNATIONAL SERVICES**
**CREDIT CARD AUTHORIZATION FORM**
(The following information is strictly confidential )

I authorize the Anadolu Medical Center to charge my credit card in event of the following :

- If an open balance exists on my account after final charges have been posted for medical services provided (This may occur because all up-front payments collected are based on **estimates** only which may vary from actual final charges.)
- **FOR PATIENTS POSSESSING PRIVATE INSURANCE :**
- Iack now ledge financial responsibility for any health insurance deductibles, co-insurance, or failure of any insurance carrier to pay the hospital or physician's charges in full when rendered. Anadolu Medical Center may not participate with many insurance provider panels; in these situations insurance companies may reimburse the patient or subscriber directly.

I acknowledge any deposit I make is based on **Cost Estimation ONLY** and Actual Charges might vary from the estimated costs. I acknowledge responsibility for any balance due between the Cost Estimation and the Actual Charges.

| | | |
|---|---|---|
| ☐ **American Express** | ☐ **MasterCard** | ☐**Visa** |
| **Credit Card Number**_____ | | **3/4 Digit s**_____ |
| **Expiration Date**_____**/**_____ | | |
| **Card Holder** | | |
| **Name**_____ | | |
| **Card Holder Signature**_____ | | |
| **Patient Name**_____ | | |
| | | |

PLEASE COMPLETE THE INFORMATION REQUESTED ABOVE AND FORWARD TO :

Anadolu Sağlık Merkezi
Attn : Sevil Tahir
Anadolu Caddesi No:1 Bayramoğlu Çıkışı
ÇayırovaMevkii,Gebze 41400 Kocaeli /Turkey
Tel: +90 262 678 57 64
Fax:+90 262 654 00 53
E-mail : sevil.tahir@anadolusaglik.org

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For your convenience, please note that Anadolu Medical Center accepts the following methods of payment: Visa, Master Card and Cash at the time of service. Should you prefer to wire transfer initial deposits to secure scheduled appointments, or, for the cost of schedule procedures to funds to Anadolu Medical Center, please do so as follows

**BANK ACCOUNTS**

**Beneficiary name: Anadolu Egitim Sosyal YardimVakfiSaglik Tesisleri IktisadiIsletmesi**

**Bank name: AlternatifBank A.S.**

**SWIFT CODE : ALFBTRIS**

**TL IBAN : TR150012409400TRY001407470**

**$ IBAN : TR250012409400USD001411961**

**€ IBAN : TR490012409400EUR001411962**

It is essential that you note the **patient's name** and **history number** as reference on this wire transfer. Also, please fax **a copy of your wire confirmation** to:

International Services

Attn: **Sevil Tahir**

Tel: +90 262 678 57 64
Fax:+90 262 654 00 53
E-mail : sevil.tahir@anadolusaglik.org

**Please feel free to contact the International Services at ……**if you have any further questions o inquiries. Thank you for choosing Anadolu Medical Center for your health care needs.