



Cost of Treatment Agreement

Made at Srinagarind Hospital

Day _____ Month _____ Year _____

In this agreement, I, Mr. Mrs. Miss _____

age _____ occupation _____ House Number _____ Street _____

Village _____ Tambol _____ Province _____

Mobile Phone _____ Work Place _____ agree to the following terms of payment:

1. I am being admitted to Srinagarind Hospital from date _____ and will follow the hospital rules and the treatment regime as prescribed by the doctor
2. I know and understand the regulations concerning the cost of treatment and hospitalization in the Faculty of Medicine, Khon Kaen University.
3. Every three days I will pay the cost of my hospitalization when informed by the hospital of the amount incurred.
4. In case I cannot pay the full cost of the three days, I will be responsible to pay it all within 7 days. If I am still unable to pay in 7 days, I am willing to be discharged from the hospital immediately.
5. I will have 30 days to pay the portion of the hospital bill I am unable to pay at the time of discharge. After that, the remaining debt will accrue interest at a rate of 15% annually.

I have read this document carefully and understand it well, agree to the terms and sign this document in front of witnesses.

_____ Patient

Witness _____

_____ Witness