EVEN HOSPITALS

Race Course Road, Bangalore 560001

FINANCIAL ESTIMATION COUNSELLING FORM

PATIENT DETAILS

Patient Name:	RAM2	**Age / Sex:**	30 / Male
UHID:	UHID3456	**Contact Number:**	8888888888

ADMISSION DETAILS

Admitting Consultant:	Binita		
Date of Admission:	08-May-2026	**Arrive by:**	04:00
Proposed Procedure:	Lap appendicectomy		
Date of Surgery:	08-May-2026	**Planned Time:**	08:00
Payer:	Insurance	**Insurance Details:**	XX
Expected LOS (Days):	1	**Admission To:**	Ward
Bed Category:		**Admission Type:**	Package

FINANCIAL DETAILS

Package Amount:

Advance to Collect: Rs. 10,000

INCLUSIONS	EXCLUSIONS
• Bed & nursing charges	• Cross consultations (if any)
• Routine medicines & consumables as per treatment / surgery / procedure planned	• High value investigations - CT, MRI etc. (if any)
• Visit charges of the treating consultants	• High value drugs (if any)
• Treatment / Surgery / Procedure charges as mentioned above	• Overstay charges (beyond expected length of stay)
• Routine OT medicines & consumables	

DISCLAIMER: The cost mentioned above is an estimated cost. Final bill may vary due to various reasons like clinical conditions, change in line of treatment, other co-morbidities etc.

NOTE:

1. Kindly make 80% of the estimated cost as a deposit before surgery.
2. Cash payment limit is Rs.1.99 Lacs only as per Section 269ST of the Income Tax Act, 1961.
3. Accepted payment modes are Credit Cards, Debit Cards, Online Transfers, UPI, Cash.
4. Cash Refund limit is restricted to only Rs.10,000/-. Refund amount in excess will be done through Bank Transfer, for which it may take 4-5 working days.
5. Non Medical, Co-pay & other deductions by insurance should be paid by customer based on the insurance approval.

HOSPITAL BANK DETAILS

Name of the Account:	Balloon Health Care Pvt. Ltd.
Account No.:	50200111991320
Account Type:	Current Account
IFSC Code:	HDFC0001472
Name & Address of the Bank:	HDFC BANK, 418/1, Near Kudalahalli Gate, ITPL Road, Bangalore - 560066, Karnataka, India

Remarks: [sheet:ram2|uhid3456]

Counselled By: A **Admission Done By:** B

PATIENT / ATTENDER CONSENT

I, the undersigned, acknowledge that I have been counselled regarding the estimated cost of treatment / procedure / surgery planned. I understand that this is a provisional estimate and that actual charges may vary based on the patient's clinical condition, length of stay, or any unforeseen complications. I agree to take full responsibility for all charges incurred during the course of treatment, including those exceeding this estimate.

Signature: _____ **Date & Time:** _____

Name: _____ **Contact No.:** _____

Relation: _____