THE PRINCE PHILIP DENTAL HOSPITAL

Private Fee Paying Patient's Declaration Form

In connection with the treatment (inclusive of oral or radiographic examinations) as a private fee paying patient (private patient) at The Prince Philip Dental Hospital (the Hospital) of **myself / my child/ the person concerned***

(*Name in BLOCK letter:* _____ *Identification Document No.:* _____),

I hereby declare (on behalf of my child/ the person concerned) that:

1. I have read and fully understood the "Notice to Private Fee Paying Patients" (version dated 28.11.2016) and "Statement of Collection of Personal Information from Patients" before registration;

Functions of the Hospital

2. I understand that the prime function of the Hospital is to provide facilities for the training of dentists and other persons in professions supplementary to dentistry. The Hospital does not provide public dental services. I understand that only certain authorised teaching staff of the Faculty of Dentistry of the University of Hong Kong (the University), with the assistance of the Hospital staff, could attend to private patients. Hence, the Hospital may not be able to offer comprehensive dental services to private patients;

Treatment/ Consultation Arrangements

3. I accept without any claim against the Hospital that the Hospital has the absolute discretion to discharge me/ my child/ the person concerned from the care and attention provided at the Hospital for reasons such as failure to attend a scheduled appointment on time twice, absence without giving one working day's prior notice, refusal to receive further treatment, failure to be contacted, failure to follow the treatment schedule, non-compliance with the recommended treatment plan/ dental advice, or having unreasonable expectations, etc.; I also understand that this is not an exclusive list, and the ultimate decision to discharge a patient rests with the Hospital;

4. I understand that in the case of emergency, the Hospital may advise me/ my child/ the person concerned to seek further dental or medical attention or treatment elsewhere, which I will accept without any claim against the Hospital;

5. I understand that I/ my child/ the person concerned have/ has to use the dental consumables, dental appliances or dental materials provided by the Hospital; and I shall have no claim against the Hospital due to any loss and damage arising from the inherent defects of such materials.

Initial Deposit, Fees and Charges

6. I agree to pay a deposit of HK$1,000 on registration as a private patient. The deposit is non-interest bearing and will be refunded when treatment has been completed, and all fees and charges (including charges for the services rendered by other persons or institutions in the course of treatment) have been paid. I agree that if the deposit cannot be refunded due to loss of contact with me for a period of three years after discharge, the Hospital will recognise the deposit as its income;

7. I understand that it is my responsibility to ask my consulting clinician(s) about the treatment fees and charges (inclusive of charges for radiodiagnostic services, dental appliances and other cost recoverable items) which I understand may vary according to the oral conditions of individual patients;

8. I understand that if services from other persons or institutions are needed (e.g. pathology testing or radiodiagnostic services), I have to pay the corresponding charges. If situation allows, service providers will charge me for their services direct; otherwise, I have to pay the charges through the Hospital together with an administrative overhead charged by the Hospital;

9. I agree to pay the fees and charges of the Hospital as prescribed in the Schedule of Fees which I understand may vary from time to time. I accept without any claim against the Hospital, that if I fail to settle the fees within the specified period, the Hospital has the absolute right to discharge me/ my child/ the person concerned from the care and attention provided at the Hospital; and

10. I understand that I should not accept any demand notes or receipts issued by individual staff of the Hospital/ the Faculty outside the invoicing system of the Hospital; and that all the Hospital fees and charges must be paid to the Hospital's Shroff Office (1/F) directly, but not to any other staff.

[If you are signing for the patient, please give details: (i) Name in BLOCK letter: _____*;*

(ii) Identification Document No.: _____*; (iii) Relationship with patient:* _____*]*

_____ _____

Signature of **patient/ guardian*** Date

Original: Patient Record
**Delete as appropriate*

PPDH 330B (Rev. 11.2016)