CONSENT AND APPROVAL FORM

Date :

A. I am NOT entitled to General Health Insurance. I was informed about current prices. I declare, accept and undertake that my examination and treatment will be carried out at these prices, that I will pay the service fees that will occur at your current prices and that I will not apply to ANY INSTITUTION for the reimbursement of this fee.

Patient's and/or his/her relatives'

Name – Surname: TRIAL TRIAL **T.R. Identity Number** **File/ Prot No** **Signature**

B. I am a General Health Insurance Beneficiary, I was informed about your current prices in paid status. I hereby accept and undertake to have the service performed at the secondary private health institution and to pay the fee at the current prices for the services that I know that I will benefit from the institutional payment at the current prices and/or at the tertiary health institutions without being invoiced to the Social Security Institution. I declare, accept and undertake that I will not apply to the Social Security Institution for the reimbursement of this fee.

Patient's and/or his/her relatives'

Name - Surname : TRIAL TRIAL **T.R. Identity Number** **File/ Prot No** **Signature**

C. I am entitled to General Health Insurance. Within the scope of the contract between the PRIVATE OPTIMED HOSPITAL and the SOCIAL SECURITY INSTITUTION (SSI); Except for the fee to be paid by the Social Security Institution for the health service (examination, examination / analysis, intervention, surgery and all kinds of complications) to be provided to me, during the continuation of the procedures for the diagnosis and treatment of my disease, I accept the additional fees to be requested by the PRIVATE OPTIMED HOSPITAL according to the Health Implementation Communiqué 1.9.1.1, 1.9.4 and 1.9.5 in accordance with Articles 1.9.1.1, 1.9.4 and 1.9.5 of the Health Implementation Communiqué, to pay the services provided to myself and / or my relatives under the name of "outpatient and inpatient general operating expenses" other than the examination, examination, treatment procedures specified in Article 1.9. 1 of the Health Implementation Communiqué, I agree to pay the services provided to myself and / or my relatives other than the examination, examination and treatment procedures specified in Article 1.9.1.1 of the Health Implementation Communiqué under the name of "outpatient and inpatient general operating expenses", and according to Article 64 of the Social Insurance and General Health Insurance Law No. 5510, when the procedures that are not financed by the Institution are medically necessary or when I request, the fees to be accrued to me in accordance with Article 1.9.1.4 of the Health Implementation Communiqué 1. 9.1.1.4. article of the Health Implementation Communiqué and that I agree to pay these amounts voluntarily and that they will not be reimbursed to me by the SSI, that I will not apply to the SSI for this purpose and that I have no such right, I declare, accept and undertake.

I declare, accept and undertake that I and/or my relative have been provided with a document detailing the procedures applied in accordance with Article 12.7 of the Agreement, that Necessary procedures are carried out in accordance with Health Implementation Communiqué 1.8.1.4 or 1.8.5, that in addition, if the documents indicating that I am a beneficiary remain incomplete or cannot be completed, I will pay the cost of all services I will receive from PRIVATE OPTIMED HOSPITAL at your current prices and if I cannot submit the documents in question despite being informed and warned at the time of application, that I will not be able to request a refund retrospectively following the commencement of my examination and treatment after making an advance payment, that I will not make this problem a subject of complaint because this problem is caused by my approach, and that I have read and understood this commitment letter and the articles of the aforementioned contract and the Health Implementation Communiqué.

Patient's and/or his/her relative

Na**me - Surname :**TRIAL TRIAL **T.R. Identity Number** **File/ Prot No** **Signature**

D. I am a BENEFICIARY of the social security institution. Pursuant to Article/64 of the Social Security and General Health Insurance Law No. 5510 (as a result of the determination of the method, type, amount and duration of use), I declare, accept and undertake to be treated at the current prices of your Centre for health services excluded from the scope of health services to be financed by the Institution, that I have been informed that these fees I will pay according to Article 1.9.1.4 of the Health Implementation Communiqué will not be considered as additional fees, and that I will not apply to any Institution for the payment of the related service fees.

Patient's and/or his/her relatives'

Name – Surname:TRIAL TRIAL **T.R. Identity Number** **File/ Prot No** **Signature**

E. I was informed before the procedures were carried out that my treatment expenses at the private hospital would be paid to the hospital by myself or my legal representative.

Patient or Patient Representative Signature	Physician Guest Pysician Responsible Signature	Guest Physician Signature	Responsible Manager / Head Signature

ANNEX 2 CONSENT FORM

In order to benefit from health services, I consent to the collection of biometric data for identity verification in accordance with Article 67 of the Social Insurance and General Health Insurance Law No. 5510.

Date: 09 March 2023 Wednesday 09:31

Name - Surname	T.R. Identity Number	File No:	Signature	Prot No :
TRIAL TRIAL				

INFORMATION ON THE LAW NO. 6698 ON THE PROTECTION OF PERSONAL DATA

Pursuant to LPPD No. 6698, your personal data that you share with our hospital may be processed in whole or in part, automatically or by non-automatic means, provided that it is part of any data recording system, by obtaining, recording, storing, and subject to any kind of processing performed on the data. Any operation performed on the data within the scope of LPPD is considered as "processing of personal data". Your personal data is collected in order for the institution to fulfil its obligations arising from the legislation in force and legal and contractual obligations, to provide health and support services, and to carry out business activities. Fulfilling our legal obligations in the Basic Law No. 3359 on Health Services, Decree Law No. 663 on the Organisation and Duties of the Ministry of Health and Affiliated Institutions, Regulation on Private Hospitals, Regulation on the Processing of Personal Health Data and Ensuring Privacy and other relevant regulations in order to fulfil the Legislation and Legal Obligations, Protection of public health, preventive medicine, For the purpose of conducting medical diagnosis, treatment and care services, planning and management of health services and financing, for the purpose of organising processes related to the Institution and improving service quality, for the purpose of verifying your rights under health contracts, for the purpose of institutional invoicing, for the purpose of responding to the requests of other public institutions and organisations, especially the Ministry of Health.

My mobile phone number and e-mail address, which we reported during the registration phase, were sent to Optimed Sağlık Hizmetleri San. Tic. A.Ş. can be used by Optimed Sağlık Hizmetleri San. Tic. A.Ş. for short messages (SMS, MMS, e-mail, appointment, survey, etc.) and calls with reminder, information, promotion and advertisement content, provided that my phone and e-mail address will not be shared with other institutions and persons.

Signature

1.7.2 - FAILURE TO RECEIVE PROVISION DUE TO REASONS ARISING FROM THE MEDULA SYSTEM

(1) Provided that it is certified by a report to be signed by the authorities of the General Directorate of Service Delivery of the Institution, the health services of the persons who apply by declaring or documenting in writing that they have the right to benefit from the health benefits of the Institution during the period when the patient tracking number cannot be obtained due to the failure of the MEDULA system are covered by the Institution. If it is determined that these persons are not eligible as a result of the subsequent enquiry, the invoice amount of the treatment is paid to the relevant health institution/organisation and the necessary legal proceedings are carried out by the Institution.

INFORMATION FORM ON THE END OF THE EMERGENCY

I accept and undertake that my emergency condition has ended after my treatment at the PRIVATE OPTIMED INTERNATIONAL ÇORLU HOSPITAL, to which I applied due to my emergency condition, and that I will pay an additional fee according to the procedures and principles determined by the Social Security Institution for the health services to be provided from now on and that I will not claim the additional fee I paid from the Social Security Institution.