APPENDIX NO. 2

Patient Questionnaire

Public contract for the provision of paid services · LLC "SKY-WINNER", Helyos Centre for Family Health and Rehabilitation

1. **Surname, first name, patronymic:**

2. **Date of birth:**

3. **RNOKPP (taxpayer number):**

4. **Contact details:**

   Mobile telephone:

   E-mail:

   Postal address:

5. **I give my consent to the following persons receiving information about the state of my health and my medical records:**

By signing this Patient Questionnaire, I confirm the validity and accuracy of the information I have provided, and also confirm that I have read and agree to the terms of the Public contract for the provision of paid services together with all its appendices, which are published on the Provider's Website.

I have also read the Internal Rules (of patients' stay) of the Medical Centre, published on the Provider's Website, and I understand that I may be refused the Services because of a breach of them.

In the event of non-payment or incomplete payment of the cost of the Services provided by the Provider to the Patient and accepted by the latter by a Third party which acts in my interests and has previously undertaken to pay for the Services provided, I undertake to pay for the Services actually provided in full, or accordingly for that part of them which the Third party (including but not limited to an Insurance company or a Charitable organisation/fund) refuses to pay.

date

signature