



Hôpital de Braine-Waterloo (723)  
Rue Wayez, 35  
1420 BRAINE-L'ALLEUD

**1. Purpose of the admission declaration: enable informed choices to be made by providing information concerning the financial consequences of the admission**

Every hospitalisation involves expenses. As a patient you may make certain choices which will have a considerable effect on the final cost of your hospital stay. These choices are made by means of the admission declaration. It is therefore very important that, before completing and signing it, you read the accompanying explanatory document carefully. If you have any questions, do not hesitate to **the relations patients from 1.00 pm to 3.30 pm (except Wednesday) at 02/434.73.04.**

**2. Choice of room**

The possibility of freely choosing my doctor will not be affected in any way by the type of room that I choose.

I wish to be admitted and treated:

**without fee or room supplements in a :**

a shared room (Site HBW)  two-bed room (Site HBW)

a private room (Site HBW (One day hospital)) with a room supplement of 136 € per day

**I am aware that in the case of admission to a private room, the hospital doctors may invoice a fee supplement of a maximum of maximum 300%.**

**3. Admission of a child accompanied by a parent**

I wish that my child, whom I will accompany, be admitted and treated at the legal rate, **without room or fee supplements.**

**I am aware that the admission will be to a two-bed room or a ward.**

I expressly wish that my child, whom I will accompany, be admitted and treated in a **private room, without room supplement.** I am aware that, in the case of **admission to a private room**, the attending doctors may **charge a maximum fee supplement of 300 %** of the legal rate for medical services.

**The costs for my stay as an accompanying parent (particularly bed, meals, beverages etc.) will be charged to me** at the rates given in the summary of prices for current goods and services..

**4. Deposit**

**I am paying ..... euro as a deposit for my stay.**

The present signed admission declaration is valid as a receipt for the deposit paid. The deposit will be deducted from the total amount of the patient's final invoice.

**5. Invoicing conditions**

**All hospital costs will be billed by the hospital. Never pay directly to the doctor!**

Our invoices are payable to a Chirec bank account ten days after they have been sent.

Failure to pay an amount after 14 calendar days taking place on the third working day following the sending of a reminder will result in the application of late payment interest calculated at the legal rate, as well as a flat-rate compensation amounting to:

- a) 20 euros if the remaining amount due is less than or equal to 150 euros;
- b) 30 euros increased by 10% of the amount due in the amount between 150.01 euros and 500 euros if the remaining amount due is between 150.01 euros and 500 euros;
- c) 65 euros increased by 5% of the amount due exceeding 500 euros, with a maximum of 2,000 euros if the remaining amount due is more than 500 euros.

The same interest will be applied, under the same conditions, in the event the hospital fails to perform a contractual obligation to the patient.

In the event of a change of address, the patient undertakes to inform the hospital by e-mail at [facture@chirec.be](mailto:facture@chirec.be).

Every patient has the right to obtain information on the financial consequences of a hospital stay and the type of room they have chosen. Every patient has the right to be informed by the doctor concerned of the costs to be paid for the medical treatments to be anticipated.

**6. Attached Documents**

I hereby declare that I have received as appendices to this declaration :

- An explanatory document which mentions the room and fee supplements. A summary of the prices of the goods and services provided in the hospital is also included and can be consulted. I know that not all costs can be foreseen.
- A document explaining the self-employed status of the doctors working in the establishments managed by CHIREC npo.

Done at \_\_\_\_\_ on \_\_\_\_\_ to \_\_\_\_\_ hours in two copies for an admission beginning on \_\_\_\_\_ TO \_\_\_\_\_ hours.

For the patient or his/her representative          First name, surname of patient or his/her representative (with national register n° )	For the hospital
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