Annex #2 to Medical Services
Agreement #______________

PATIENT INFORMED CONSENT
For medical treatment (chargeable medical services)

1. I, the undersigned,____
(Full name of the patient / patient's legal guardian (parents, adoptive parents or foster parents)), hereinafter Patient/ Legal guardian of the Patient
have sought medical treatment at State-funded health institution in Kamchatski Krai, Petropavlovsk-Kamchatski «City Clinic for children #1», located at: 683031, Kamchatskiy Krai, Petropavlovsk-Kamchatskiy, 5 Voitsesheka str (hereinafter referred to as "Clinic") to receive chargeable medical services and hereby I confirm the following:

Consulting physician has guaranteed the confidentiality of all information provided to him.

The full information on the Clinic, including full name, address, opening hours, types of services provided and information on the medical licenses of the Clinic was provided to me.

I received thorough information on medical services, including those that will be provided to me: quality of the services, main consumer properties, list of services and their price, types of services, conditions and rules of their safe and effective rendering, information on qualifications and certificates of the doctors, on place, where services are rendered as well as addresses and phone numbers of superior authorities and consumer rights protection services.

I confirm that I've been given all information on the state of my health: on my medical problems, diagnosis, the medical help necessary, different approaches to interpreting screening results, possibilities of medical treatment, its prognosis, consequences and degree of risk.

I was informed that I have to tell my doctor if I feel unwell, or cannot fulfill my obligations under this Agreement. I can also file complaints, comments and suggestions addressed to officials and medical director.

I confirm that all information provided to me by my doctor is time-sensitive, necessary, truthful and clear.

In view of this I am fully informed and give my willful informed consent for chargeable medical services which are necessary to me.

I was informed and I understand that unforeseen circumstances and complications can arise while medical services are being rendered to me. In such case I agree that type and strategy of medical treatment can be changed by the doctors as they see fit.

Information on the persons, who can be provided with information on the state of my health or the state of health of the individual under my guardianship (please cross out the inapplicable information), chosen by me in accordance with clause 5 section 5 Article 19 of the Federal law #323-ФЗ "On fundamental healthcare principles in the Russian Federation" dated November 21, 2011

_ __________________________ __________________ ____(Person's full name and contact number)

I am aware of the possibility to receive free scheduled medical treatment under Compulsory Health Insurance Program (by appointment) und agree to receive this service for a fee.

I have read and fully understood the contents of this document, as Annex to the Agreement and certify it with my signature.

I give permission to processing of my personal data.

______________________ Signature of patient (patient's legal guardian)	______________________ Signature of physician
______________________ (Full name.)	______________________ (job title)
______________________ (Signature)	______________________ (Signature, Full name)
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The patient is informed that he/she can get this medical service for free under Compulsory Health Insurance Program.

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(Full name, signature, date)