

# Institute of Rheumatology

State-funded institution

Na Slupi 4, 128 50 Prague 2, ID No.: 00023728

## AGREEMENT ON ADVANCE PAYMENT FOR PROVISION OF HEALTH CARE

**Name and surname of patient:** \_\_\_\_\_

**Date of birth:** \_\_\_\_\_

**Passport or ID card number:** \_\_\_\_\_

**Nationality:** \_\_\_\_\_

**Place of residence in the Czech Republic (as stated in ID document):** \_\_\_\_\_

The above-mentioned patient and his/her attending doctor have agreed that the patient shall make an advance payment to the cashier of the Institute of Rheumatology for health care that he/she has requested and agreed to in the scope recommended by the attending doctor.

Anticipated cost of provided health care \_\_\_\_\_ CZK

Amount of advance payment to be made to the IR cashier \_\_\_\_ CZK

In Prague on:

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signature and stamp of the attending doctor

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signature of patient