Adopté:

par ordre du médecin en chef GBUZ JSC «DGP №3»

du 01.11.2013 № 183

**CONTRAT №\_\_\_\_\_\_\_\_\_**

**pour la fourniture de services médicaux payants**

v. Astrakhan «\_\_\_\_\_\_\_\_» \_\_\_\_\_\_\_\_\_\_\_\_\_\_202\_\_\_\_\_a.

D'etat le projet de budget de l'institution de soins de santé de la région d'Astrakhan «de l'Aire urbaine de la polyclinique № 3» (GBUZ JSC «DGP № 3»), ci-après dénommée "organisation Médicale" dans le visage d'un médecin-chef Минаковой Galina Митрофановны, agissant sur la base de la Charte et de la licence d'activité médicale no LO 30-01 001945 de 12.12.2018 avec une durée de validité illimitée, fournis par le ministère de la santé de la région d'Astrakhan (414056 м. Astrakhan, rue de l'Татищева,16 «dans», c' (8512) 54-92-30, 54-00-14) d'une part et le citoyen

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nom de l'enfant (représentant légal), année de naissance, lieu de résidence,

en tant que représentant légal du mineur (F. I. O. complètement, l'année de naissance, lieu de résidence), ci-après dénommé «le Client» ou «Patient», d'autre part (ci-après, ensemble, ci-après dénommée «les Parties»), sous réserve des dispositions Fédéral заколот 21.11.2011 № 323- loi fédérale «Sur la base de la bonne santé des citoyens de la Fédération de russie, du code Civil de la Fédération de russie, la Loi de la Fédération de russie «Sur la protection des droits des consommateurs», les Règles d'octroi des organismes compétents de péage de soins de santé approuvé par le décret du Gouvernement de la Fédération de russie de 04.10.2012 № 1006, ainsi que les Règles pour la fourniture de services payants à GBUZ JSC "DGP №3", ont conclu ce contrat (ci - après-le contrat) sur ce qui suit:

**1. Objet du Contrat et modalités de calcul**

1.1. L'exécuteur s'engage à fournir des services médicaux payants au Patient et le Patient s'engage à accepter et à payer les services aux termes du présent Contrat.

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| --- | --- | --- | --- | --- | --- |
| **№ n/n** | **Code du service médical** | **Compartiment** | **Nombre de jours de service ou de patient** | **Le prix d'un service ou d'un patient par jour** | **Coût des services médicaux** |
| 1 |   |   |   |   |  |
| 2 |   |   |   |   |  |
| 3 |  |  |  |  |  |
| 4 |  |  |  |  |  |
| 5 |  |  |  |  |  |

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| **Executor:**Legal address: 414041, g, Astrakhan, ul. Kulikova, 61Tel / Fax: (8512) 31-77-00 website www/ 3dgp.ruE-mail: gbuzao.dgp3@mail.ruOGRN 1023000819522, INN 3015035026, KPP 301501001Ministry of Finance of the Astrakhan region (GBUZ AR "Children's city polyclinic № 3")P / s 40601810300003000001Department of Astrakhan AstrakhanL / s 22854SH05816 BIC 041203001 | **Patient** (legal representative of the patient, Customer):Full name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_The identity document \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Series, number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of issue\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Issued by whom\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Residence\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Patient's phone number(the patient's legal representative) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/G. M. Minakova / \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/

**VOLUNTARY INFORMED CONSENT TO PROVIDE PAID MEDICAL SERVICES**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, (name of patient) "\_\_\_\_\_" \_\_\_\_\_\_\_\_\_\_\_\_ b. e.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, (name of the legal representative of the patient) acting on behalf of his minor child for purposes of this agreement, I wish to receive medical services in GBUZ AR "DGP № 3". At the same time the following has been explained to me and realized by me:

1.I have received full information from the employees of the institution about the possibility and conditions for providing me with free medical services in this medical organization under the program of state guarantees for receiving free medical care in the territory of the Astrakhan region, I give my consent to provide me with paid medical services and I am ready to pay for them.

2. it is explained to Me that I can get both one of the types of paid medical services, and several types of services.

3. my rights and obligations in the sphere of health protection were explained to me by the medical organization's employees in accordance with the Federal law of the Russian Federation № 323-FZ of 21.11.2011 "on the basics of public health protection in the Russian Federation".

4.I agree that the used technology of medical care can not completely exclude the possibility of side effects and complications due to the biological characteristics of the body, and in the case when the service is provided in compliance with all necessary requirements, the medical organization is not responsible for their occurrence, and that if the above-mentioned side effects and complications of medical intervention require urgent medical care, the GBUZ AR "DGP № 3" will provide it without additional payment.

5.I am aware and understand that in order to obtain the best results of treatment, I must comply with all prescriptions, recommendations and advice of doctors of the medical organization, failure to comply with which may reduce the quality of the service provided, lead to the inability to complete it on time or adversely affect the health of my minor child.

6. the Types of paid medical services I have selected have been approved by my doctor, and I agree to pay for them.

7. I have read the current price list for paid medical services and agree to pay the cost of the medical service (s) in accordance with it.

8. I have been informed that I can get medical care from other medical organizations for my existing illness, and I confirm my consent to receive the specified medical service (s) from this medical health organization.

9.I certify that I have read the text of my informed consent to medical intervention, that I understand the purpose of this document, that the explanations received are clear and that I am satisfied. This informed consent was signed by me after a preliminary interview and is an Annex to the contract for the provision of paid medical services.

Patient (legal representative) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/

 Signature transcript of the signature

Signature of medical worker \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ “\_\_\_\_\_”\_\_\_\_\_\_\_\_\_\_\_\_ 20 \_\_\_\_\_\_

The Customer can get acquainted with the license for medical activities when signing this agreement. The license is published on the official website of the medical organization, and is also available to specialists who provide paid services.