مركز أوركيد الطبي
ORCHID MEDICAL CENTER

صحة ... ابتسامة ... جمال
Health ... Smile ... Beauty

Date: 08 / 01 / 2019 File Number: 1001441

Patient Name: Asham kamal Abu Helweh. إسم المريض :

Date Of Birth (تاريخ الميلاد) 21 / 06 / 2006 Gender (الجنس) : M / F Marital Status:(الحالة الاجتماعية) .....

Nationality (الجنسية): Jordan Occupation (الوظيفة) : .....

Address (العنوان) : Sharjah Phone No. (رقم الهاتف): 0506578706

E-MAIL: ..... How did you know about us: Google

Medical History التاريخ الطبي

Medical Condition الحالة الطبية	Yes/No نعم / لا	If 'YES' give details اذا كانت الاجابة نعم اذكر بالتفصيل
Recent or current drugs/Medical Treatment هل تتعاطى أي أدوية أو تتلقى اي علاجات حديثا؟	لا	
Cortisteroids/Immunosuppressant هل تتعاطى أي ستيرويدات او مثبطات للمناعة؟	لا	
Allergies هل لديك أي حساسية؟	لا	
Surgical Operations, Serious Illness هل اجريت أي عمليات جراحية او تعاني من اي امراض؟	لا	
Cardiac surgery, Rheumatic fever, Endocarditis, Artificial heart valve, Congenital heart disease جراحة قلب، حمى روماتويد، التهاب شغاف القلب، صمام قلب صناعي، امراض القلب	لا	
High Blood Pressure, Bleeding disorders, Anticoagulants هل لديك ارتفاع في ضغط الدم، مشاكل في النزيف او تتعاطى أي مميعات للدم؟	لا	
Anemia, Leukemia انيميا (فقر الدم)، لوكيميا (سرطان الدم)	لا	
Chest disease, Asthma, Bronchitis, TB, Other امراض صدرية، ازمة تنفسية، التهاب في القصبات، السل، امراض اخرى	لا	
Renal, Urinary, Sexually transmitted disease هل تعاني من اي امراض في الكلى او امراض بولية او تناسلية؟	لا	
Pregnancy, Contraceptive pill, Menstrual problems هل انت حامل؟ هل تتعاطين اي مانع للحمل؟ هل تعانين من مشاكل في الدورة الشهرية؟	لا	
Hepatitis, Jaundice, Other liver diseases التهاب الكبد الوبائي ، الصفراء، اي امراض كبدية اخرى	لا	
Peptic ulcer, Crohn's ulcerative colitis, Other قرحة معوية، داء كرون، أي امراض معوية أخرى؟	لا	
Epilepsy, or any other neurological disease هل تعاني من الصرع او اي امراض في الجهاز العصبي؟	لا	
Thyroid Diseases, Diabetes هل تعاني من مرض السكري او امراض الغدة الدرقية؟	لا	
Other conditions هل تعاني من أي امراض أخرى؟ HSV, HIV...etc فيروس الايدز، فيروس الحلأ البسيط	لا	

مركز أوركيد الطبي
ORCHID MEDICAL CENTER

صحة ... ابتسامة ... جمال
Health ... Smile ... Beauty

نموذج اقرار طبي

أوافق و أسمح للطبيب بعلاج حالتي المرضية التي تم شرحها لي من قبل الطبيب المختص و المؤهل.

أتفهم أن بعض الإجراءات الطبية والتشخيصية الاضافية قد تكون ضرورية من أجل تزويدي بالعلاج الأمثل و الخدمة الافضل.

أتفهم أنه من الممكن أن يكتشف الطبيب خلال العلاج أمورا مختلفة عن ما ذكر في الفحص الأولي و التي قد تتطلب إجراءات إضافية أو مختلفة عن تلك المخطط لها.

أفوض الطبيب المعالج باتخاذ كل الاجراءات الطبية و العلاجات اللازمة و المطلوبة بحكم خبرته المهنية و العلمية.

اقر أنه لم يتم تقديم اي ضمانات او تأمين لنتائج العلاجات و الاجراءات الطبية او التجميلية المقدمة لي، كما اتفهم الاخطار و المضاعفات الناتجة عن عدم استكمال علاج حالتي المرضية.

أتفهم تماما كافة الاخطار و المضاعفات التي قد تكون مصاحبة للفحوصات والاجراءات العلاجية و الجراحية.
و ادرك ان بعض الاجراءات التشخيصية و العلاجية و الجراحية قد تؤدي الى .مضاعفات كالالتهاب أو التورم أو النزيف أو الألم أو الحساسية

أتفهم أن هناك رسوم بالحد الأدنى يجب علي دفعها مقابل الخدمة العلاجية و أن جميع الرسوم المطلوبة يجب ان تسدد بالكامل قبل الانتهاء من العلاج.

أقر أن كافة المعلومات الطبية و التاريخ الطبي الذي قدمته لدى فتحي للملف صحيحة. و اتفهم ان اي معلومات تتعلق بحالتي الصحية ستبقى سرية تماما ولا يمكن الاطلاع عليها دون موافقتي

أقر أن لدي المعلومات الكاملة لتقديم هذا الاقرار و ان هذا النموذج قد تم شرحه لي بالكامل و اني قد قرأت و فهمت جميع تفاصيله بالكامل و اني وقعت عليه بكامل ارادتي

توقيع المريض / ولي الأمر (لمن هم دون السن القانونية):

التاريخ: ... / ... / .....

Medical Consent Form

I hereby consent and authorize the doctor to treat my medical condition which has been explained to me by the qualified physician

I understand that in order to provide me with the most efficient and enhanced service, diagnostic and other procedures may be deemed necessary.

I understand that my treating doctor may discover other or different conditions, which may require additional or different procedures than those planned.

I authorize my treating doctor to perform any procedures which are advisable in their professional judgment.

I understand that no warranty or guarantee has been made to me as a result or cure just as there may be risks and hazards in continuing my present condition without treatment.

I understand that there are also risks and hazards to the performance of the diagnostic and/or surgical procedures.
I realize that common surgical or diagnostic procedures are potential for an infection, swelling, bleeding, pain or allergic reaction.

I understand that there are minimal fees to be paid per service and that all fees must be paid in full before the completion of treatment.

I consent that all medical history and information I provided in my medical file is true and I understand that any information I provide regarding my medical status will be kept confidential and anonymous.

I believe that I have sufficient information to give this consent. I certify that this form has been fully explained to me and that I have read it and I understand its' content and I sign it with all my will.

Patient's Signature/ Guardians (In case of minors):

Date: ... / ... / .....

Patient Assesment Form استمارة تقييم المريض

Vital Signs المؤشرات الحيوية

Weight (الوزن):	Kg	Height (الطول):	cm	Blood Type (فصيلة الدم) :	
Pulse (النبض):	ppm	Blood Pressure (ضغط الدم) :	/	Blood Sugar (سكر الدم) :	

Chief Complaint سبب زيارة المريض للعيادة

Disease History :التاريخ المرضي

Allergies الحساسية

Medications الأدوية

Pregnancy الحمل

Previous Surgeries, Hospitalization
عمليات سابقة ، ادخال للمستشفى

Smoking (التدخين) : Y / N Alcohol (تعاطي الكحول) : Y / N Drugs (تعاطي العقاقير): Y / N

General & Clinical Findings الملاحظات العامة و السريرية

Examination الفحص

Radiography الصور الشعاعية

Advice – OPG

Diagnosis التشخيص

Generalized Spacing in b/L arch
$\underline{+}^3$ Transposition, $\underline{+}^2$ Missing $\underline{+}^c$ retained
Class I Molar

File No: ..... Date: / /

Treatment Plan خطة العلاج

09/1/2019 Non Extraction
Maintaing Space for $\frac{+}{2}$
Space Closing, deep bite Correction
Tt Duration - 14M - 1½ Y cost 35000
Retainer cost extra

30/1/2019 Tt plan discussed with parents
they want $\frac{+}{3}$ on place of Missing
$\frac{+}{2}$ & $\frac{+}{c}$ as it is
Upper bonding done in .018 Roth
012 Ni Ti Light
Pay 1000 AED

Doctor's Signature and Stamp

.....

مركز أوركيد الطبي
ORCHID MEDICAL CENTER

PATIENT NAME: **FILE NO#:**

DATE	TREATMENT	PAYMENT	BALANCE	SIGNATURE
08.01.19	Advance Payment for Braces Pkg total of 3500 AED	300	—	Fahim
30/1/2019	upper bonding, 012 Ni Ti	700	= 1000	
5/3/2019	Lower Bonding done, 012 Ni Ti Ligatured	300		
9/4/2019	Rebonding New Tube at #6 . 014 upper Ni Ti, 012 lower Ni Ti	300.		
11/5	Again he broke #5 Rebonding #5 O Ties Changed 3# Protraction	300		
11-6-2019	#5 is firm So 3# protraction in same wire O Ties changed	300		
1/7/19	016 Res upper, 014 w Lower	300		
4/9/2019	016 Ni Ti — Lower PC fr 3# to #3	300		
7/9/2019	desensitation of #4 Coil Spring fr 5# space	300		

REDAD DATA

cAEAIOEBAA83ODQyMI

Public Data Readed Succ

SHOW READED DATA

Confirm Data

Public Data Verification report

File	Valid Signature?
Non-Modifiable Data (SF3)	False
Modifiable Data (SF5)	False
Holder Signature Image (SF7)	False
Photography	False
Home Address	False
Work Address	False

Card Holder Information

Name	Aiham,Kamal,Yousef,,Abu Helweh	**IDN:**	784200659252751	**Mother Name:**	
Name (Ar)	ايهم,كمال,يوسف,,ابوحلوه	**Card Number:**	089092688	**Mother Name (Ar):**	
Title:		**Nationality:**	JOR	**Family ID:**	
Title (Ar):		**Nationality (Ar):**	الأردن		
Issue Date:	16/05/2018	**Sex:**	M	**Sponsor Type:**	03
Expiry Date:	14/05/2020	**Date of Birth:**	21/06/2006	**Sponsor Name:**	كمال يوسف محمد ابوحلوه
Marital Status:	01	**Husband IDN:**		**Sponsor Number:**	02210251
Residency Type:	03	**Residency Number:**	20120143102803	**Residency Expiry:**	14/05/2020
ID Type:	IL	**Occupation:**	98	**Occupation Field:**	00

Photo

Signature Image

No signature / بدون إمضاء

مركز أوركيد الطبي
ORCHID MEDICAL CENTER

) 300.00

RECEIPT VOUCHER

No: REC-002250

Date: 08-01-2019

eive from Mr./Mrs./M/s. **1001441 - AIHAM ABU HELWEH - 971505878706**

sum of Dhs. **Three Hundred Only**

Cash **0.00** / By Credit Card **300.00 (Bank Charges: 0.00)** / By Cheque **0.00** / By Bank Transfer **0.00** / By Allocated **0.00**

k: Cheque No. Date:

ıg **ADVANCE 300 AED RECEIVES FOR BRACES PACKAGE - (TOTAL AMT 3500 AED) - NON-REFUNDABLE**

le by **Ghada**

Tel : + 9716 555 8337, Fax : + 9716 528 8130, e – mail : info@omc1.ae
www.omc1.ae

مركز أوركيد الطبي
ORCHID MEDICAL CENTER

AED 1,050.00

RECEIPT VOUCHER

No: REC-002477

Date: 30-01-2019

Receive from Mr./Mrs./M/s. **1001441 - AIHAM ABU HELWEH - 971505878706**

The sum of Dhs. **One Thousand and Hundred Fifty Only**

By Cash **0.00** / By Credit Card **1,050.00 (Bank Charges: 0.00)** / By Cheque **0.00** / By Bank Transfer **0.00** / By Allocated **0.00**

Bank: Cheque No. Date:

Being **FIRST ADVANCE FOR BRACES FOR 3500 PKG (VAT 50 COLLECTED)**

Made by **Ghada**

Tel : + 9716 555 8337, Fax : + 9716 528 8130, e – mail : info@omc1.ae
www.omc1.ae

مركز أوركيد الطبي
ORCHID MEDICAL CENTER

1,050.00

RECEIPT VOUCHER (No.REC-002558)

Date:06-02-2019

Receive from Mr./Mrs./M/s. **1001441 - AIHAM ABU HELWEH - 971505878706**

The sum of Dhs. **One Thousand Fifty Dirhams and Zero Fils Only**

By Cash **0.00** / By Credit Card **0.00** / By Cheque **0.00** / By Bank Transfer **0.00** / By Allocated **1,050.00**

Bank: Cheque No. Date: **06-02-2019**

Being

Made by **Ghada**

Tel : + 9716 555 8337, Fax : + 9716 528 8130, e – mail : info@omc1.ae
www.omc1.ae

مركز أوركيد الطبي
ORCHID MEDICAL CENTER

315.00 **RECEIPT VOUCHER (No.REC-002869)** **Date:05-03-2019**

Receive from Mr./Mrs./M/s. **1001441 - AIHAM ABU HELWEH - 971505878706**

The sum of Dhs. **Three Hundred Fifteen Dirhams and Zero Fils Only**

By Cash **0.00** / By Credit Card **315.00** / By Cheque **0.00** / By Bank Transfer **0.00** / By Allocated **0.00**

Bank: Cheque No. Date: **05-03-2019**

Being **BRACES FOLLOW UP + vat**

Made by **Hiba**

Tel : + 9716 555 8337, Fax : + 9716 528 8130, e – mail : info@omc1.ae
www.omc1.ae

Reimbursement Claim Form

ضمان Daman

1. Daman Member Details and Contact Information

Name:*
(Exactly as on the Daman card)

Daman Card No:*									Mobile No.:*

E-mail Address:*

2. Claims Payment Details

Wire Transfer *(Please provide the bank account details to which Daman should transfer the money for this reimbursement claim.)*

Beneficiary Name:	
Bank Name:	Branch, Bank Address:
Account Number:	Swift Code Number (For International Transfers)
IBAN: - - - - -	

I authorise the National Health Insurance Company – Daman PJSC ("Daman") to make a wire transfer payment against this Reimbursement Claim Form and hereby discharge Daman from any liability with respect of releasing the payment to the bank details as specified by me hereinabove.

3. Medical Information

Visit Date:

Reason for visit/Chief Complaints: Spacing between Teeth not look good

Diagnosis: $\underline{1}^{2}$ Missing $\underline{1}^{3}$ Transposition, Space between teeth in both arch

Treatment Details: Fixed Orthodontic Treatment (BRACES)

Currency (If treatment is availed outside UAE):	Total Amount Paid:

4. Checklist – please check that you have included all of the following as required: *(Failure to provide the required below documents may result in rejection or delay in the processing of your claim).*

☑ Invoices/bills with a breakdown of each medical service and its unit cost. It must show a confirmation of payment or a corresponding receipt. Receipt Copy with Form 1050, 315, 300 AED

☐ Complete Medical Report/ discharge summary or a precise identification of the illness (diagnosis) or description of the symptoms by the doctor

☐ Prescription(s) for medications and medical appliances Fixed Orthodontic Treatment 1 yr.

5. Terms & Conditions/Authorisation

☐ I agree to the **Terms and Conditions** herein (refer to the terms and conditions in page 2)

☐ I hereby authorise Mr. /Ms. /Company..... to receive medical information related to this claim from Daman on my behalf.

Name of Daman member/ Legal Guardian/ Legal Representative	Signature	Date

Terms & conditions:

I, declare that the information above is correct and that the reimbursement requested is for expenses paid by me for the treatment of my covered condition.

I, hereby authorize any doctor, hospital, clinic or medical provider, any insurance company or any other company, institution or any other person who has any record or information about me and/or any of my family members to provide the National Health Insurance Company - Daman with the complete information, including copies of their records with reference to any sickness or accident, any treatment, examination, advice or hospitalization or any other information required by Daman.

I hereby declare that the information submitted to Daman is true and correct to the best of my knowledge. I am aware that any person who intentionally makes any false and/or misleading statements to obtain reimbursement from Daman shall be subject to fine and/or imprisonment in accordance with the UAE laws.

I am fully aware that in case I am not satisfied with the settlement of my Reimbursement Amount, I must contact Daman within 180 days from the date of receiving payment notification/rejection letter.

I agree that upon payment of the Reimbursement Amount, I shall transfer the ownership of my original documents to Daman and shall have no future claim against Daman with respect to these documents.

I also undertake that no claims will be made by any person or entity from Daman in future in relation to the aforesaid reimbursement claim. I undertake that in the event of any claim in future by any person to Daman for the Reimbursement Amount, Daman shall have no liability in this regard. I hereby indemnify and hold harmless, Daman and its directors, officers, employees, agents, representatives, assigns and successors from any direct or indirect costs, losses or expenses arising as a result of or in connection with the Reimbursement Amount or my reimbursement claim.

Notice:

We encourage you to **provide all the above required information** and any other **relevant documents** that support your claim, such as travel documents (for international reimbursement claim), diagnostic test and lab test results, etc.

Documents should be provided in **English or Arabic**. We will do our best to accommodate other languages, however you may be asked to provide translated documents by a professional.

All reimbursement claims have to be submitted **within 180 days** from the invoice date.

Please use our Daman mobile application or Daman's website to submit your future claims. However, all reimbursement claims **above AED 15,000** have to be submitted at one of our branches along with the original documents listed in the above checklist.

If you have any questions or need help completing the claim form, please contact us on:
Customerinfo@damanhealth.ae
800 4 32626 within the UAE or +971 2 6149555 outside UAE.
www.damanhealth.ae

مركز أوركيد الطبي
ORCHID MEDICAL CENTER

AED 315.00 **RECEIPT VOUCHER (No.REC-003287)** **Date:09-04-2019**

Receive from Mr./Mrs./M/s. **1001441 - AIHAM ABU HELWEH - 971505878706**

The sum of Dhs. **Three Hundred Fifteen Dirhams and Zero Fils Only**

By Cash **0.00** / By Credit Card **315.00** / By Cheque **0.00** / By Bank Transfer **0.00** / By Allocated **0.00**

Bank: Cheque No. Date: **09-04-2019**

Being **BRACES FOLLOW UP + VAT**

Made by **Rana**

1.Any Advance refund will be accepted within 48 hours for 25% of deduction from the total amount.
2.Treatment includes lab cost is non-refundable.
3.After 48 hours No refundable accepted

Confirmed by : **1001441 - AIHAM ABU HELWEH - 971505878706**

Tel : + 9716 555 8337, Fax : + 9716 528 8130, e – mail : info@omc1.ae
www.omc1.ae

مركز أوركيد الطبي
ORCHID MEDICAL CENTER

AED 1,050.00 **RECEIPT VOUCHER (No.REC-002558)** **Date:06-02-2019**

Receive from Mr./Mrs./M/s. **1001441 - AIHAM ABU HELWEH - 971505878706**

The sum of Dhs. **One Thousand Fifty Dirhams and Zero Fils Only**

By Cash **0.00** / By Credit Card **0.00** / By Cheque **0.00** / By Bank Transfer **0.00** / By Allocated **1,050.00**

Bank: Cheque No. Date: **06-02-2019**

Being

Made by **Rana**

1.Any Advance refund will be accepted within 48 hours for 25% of deduction from the total amount.
2.Treatment includes lab cost is non-refundable.
3.After 48 hours No refundable accepted

Confirmed by : **1001441 - AIHAM ABU HELWEH - 971505878706**

مركز أوركيد الطبي P.O.Box: 84088 Sharjah - U.A.E. ORCHID MEDICAL CENTRE

Tel : + 9716 555 8337, Fax : + 9716 528 8130, e – mail : info@omc1.ae
www.omc1.ae

مركز أوركيد الطبي
ORCHID MEDICAL CENTER

AED 300.00

RECEIPT VOUCHER

No: REC-002250

Date: 08-01-2019

Receive from Mr./Mrs./M/s. **1001441 - AIHAM ABU HELWEH - 971505878706**

The sum of Dhs. **Three Hundred Only**

By Cash **0.00** / By Credit Card **300.00 (Bank Charges: 0.00)** / By Cheque **0.00** / By Bank Transfer **0.00** / By Allocated **0.00**

Bank: Cheque No. Date:

being **300A AED RECEIVES FOR BRACES PACKAGE - (TOTAL AMT 3500 AED) - NON-REFUNDABLE**

Made by **Rana**

1.Any Advance refund will be accepted within 48 hours for 25% of deduction from the total amount.
2.Treatment includes lab cost is non-refundable.
3.After 48 hours No refundable accepted.

Tel : + 9716 555 8337, Fax : + 9716 528 8130, e – mail : info@omc1.ae
www.omc1.ae

مركز أوركيد الطبي P.O.Box: 84088 Sharjah - U.A.E ORCHID MEDICAL CENTRE

مركز أوركيد الطبي
ORCHID MEDICAL CENTER

AED 1,050.00 **RECEIPT VOUCHER (No.REC-002558)** **Date:06-02-2019**

Receive from Mr./Mrs./M/s. **1001441 - AIHAM ABU HELWEH - 971505878706**

The sum of Dhs. **One Thousand Fifty Dirhams and Zero Fils Only**

By Cash **0.00** / By Credit Card **0.00** / By Cheque **0.00** / By Bank Transfer **0.00** / By Allocated **1,050.00**

Bank: Cheque No. Date: **06-02-2019**

Being **FIRST PAYMENT FOR BRACES UPPER BONDING**

Made by **Rana**

1.Any Advance refund will be accepted within 48 hours for 25% of deduction from the total amount.
2.Treatment includes lab cost is non-refundable.
3.After 48 hours No refundable accepted

Confirmed by : **1001441 - AIHAM ABU HELWEH - 971505878706**

Tel : + 9716 555 8337, Fax : + 9716 528 8130, e-mail : info@omc1.ae
www.omc1.ae

P.O.Box: 80088 Sharjah - U.A.E. ORCHID MEDICAL CENTER

This pt. Came to our Clinic with problem of Spacing and Transposition of Canine, deep bite
So he need Tt (Orthodontic by braces) 1 ½ yr. So we start the case & ask 1500 AED for down pay.

مركز أوركيد الطبي
ORCHID MEDICAL CENTER

AED 315.00 **RECEIPT VOUCHER (No.REC-003648)** **Date:11-05-2019**

Receive from Mr./Mrs./M/s. **1001441 - AIHAM ABU HELWEH - 971505878706**

The sum of Dhs. **Three Hundred Fifteen Dirhams and Zero Fils Only**

By Cash **0.00** / By Credit Card **315.00** / By Cheque **0.00** / By Bank Transfer **0.00** / By Allocated **0.00**

Bank: Cheque No. Date: **11-05-2019**

Being **BRACES FOLLOW UP + VAT**

Made by **Rana**

1.Any Advance refund will be accepted within 48 hours for 25% of deduction from the total amount.
2.Treatment includes lab cost is non-refundable.
3.After 48 hours No refundable accepted

Confirmed by : **1001441 - AIHAM ABU HELWEH - 971505878706**

Tel : + 9716 555 8337, Fax : + 9716 528 8130, e – mail : info@omc1.ae
www.omc1.ae

مركز أوركيد الطبي
ORCHID MEDICAL CENTER

AED 1,050.00 **RECEIPT VOUCHER (No.REC-002558)** **Date:06-02-2019**

Receive from Mr./Mrs./M/s. **1001441 - AIHAM ABU HELWEH - 971505878706**

The sum of Dhs. **One Thousand Fifty Dirhams and Zero Fils Only**

By Cash **0.00** / By Credit Card **0.00** / By Cheque **0.00** / By Bank Transfer **0.00** / By Allocated **1,050.00**

Bank: Cheque No. Date: **06-02-2019**

Being **PT CAME TO THE CLINIC WITH PROBLEM OF SPACING AND TRANSPOSITION CANINE , DEEP BITE SO HE NEED TREATMENT (ORTHODONTIC BY BRACES) FOR ONE AND HALF YEAR STARTING DATE 6-2-2019 TO 6-8-2020**

Made by **Rana**

1.Any Advance refund will be accepted within 48 hours for 25% of deduction from the total amount.
2.Treatment includes lab cost is non-refundable.
3.After 48 hours No refundable accepted

Confirmed by : **1001441 - AIHAM ABU HELWEH - 971505878706**

Tel : + 9716 555 8337, Fax : + 9716 528 8130, e – mail : info@omc1.ae
www.omc1.ae

مركز اوركيد الطبي
RECEIVED
ORCHID MEDICAL CENTRE

مركز أوركيد الطبي
ORCHID MEDICAL CENTER

TAX INVOICE (NO. INV-C004727)

Patient File #	:	**1001441**	Visit Date	:	**11-06-2019**
Patient Name	:	**AIHAM ABU HELWEH**	Insurance	:	**Cash**
Doctor	:	**DR.CHINO M**	Invoice Date	:	**11-06-2019**
VAT Reg #	:	**100479302000003**			

Sl.No	Code	Service	Unit Price	Quantity	Gross	Discount	VAT %	VAT Amount	Net
1.	DEN-124	BRACES FOLLOW UP	300.00	1	300.00	0.00	5.00	15.00	300.00

Gross Total (in AED)	**300.00**
Discount (in AED)	**0.00**
Net Total (in AED)	**300.00**
VAT TOTAL	**15.00**
NET + VAT TOTAL	**315.00**
Paid (in AED) **(Credit Card)**	**-315.00**
Balance (in AED)	**0.00**
Advance Balance (in AED)	**300.00**

Prepared By Rana

BRACES FOLLOW UP + VAT

Patient Signature

Kindly note that this automated and uniquely dated invoice is payable on this visit before leaving the Center deposit will be automatically deducted upon settlement.

Tel : + 9716 555 8337, Fax : + 9716 528 8130, e – mail : info@omc1.ae
www.omc1.ae

مركز أوركيد الطبي
ORCHID MEDICAL CENTER

AED 315.00 **RECEIPT VOUCHER (No.REC-004013)** **Date:11-06-2019**

Receive from Mr./Mrs./M/s. **1001441 - AIHAM ABU HELWEH - 971505878706**

The sum of Dhs. **Three Hundred Fifteen Dirhams and Zero Fils Only**

By Cash **0.00** / By Credit Card **315.00** / By Cheque **0.00** / By Bank Transfer **0.00** / By Allocated **0.00**

Bank: Cheque No. Date: **11-06-2019**

Being **BRACES FOLLOW UP + VAT**

Made by **Rana**

1.Any Advance refund will be accepted within 48 hours for 25% of deduction from the total amount.
2.Treatment includes lab cost is non-refundable.
3.After 48 hours No refundable accepted

Confirmed by : **1001441 - AIHAM ABU HELWEH - 971505878706**

Tel : + 9716 555 8337, Fax : + 9716 528 8130, e – mail : info@omc1.ae
www.omc1.ae

مركز أوركيد الطبي
ORCHID MEDICAL CENTER

AED 315.00 **RECEIPT VOUCHER (No.REC-004277)** **Date:01-07-2019**

Receive from Mr./Mrs./M/s. **1001441 - AIHAM ABU HELWEH - 971505878706**

The sum of Dhs. **Three Hundred Fifteen Dirhams and Zero Fils Only**

By Cash **0.00** / By Credit Card **315.00** / By Cheque **0.00** / By Bank Transfer **0.00** / By Allocated **0.00**

Bank: Cheque No. Date: **01-07-2019**

Being **BRACES FOLLOW UP + VAT**

Made by **Hiba**

1.Any Advance refund will be accepted within 48 hours for 25% of deduction from the total amount.
2.Treatment includes lab cost is non-refundable.
3.After 48 hours No refundable accepted

Confirmed by : **1001441 - AIHAM ABU HELWEH - 971505878706**

Tel : + 9716 555 8337, Fax : + 9716 528 8130, e – mail : info@omc1.ae
www.omc1.ae

مـركـز أوركـيـد الـطـبـي
ORCHID MEDICAL CENTER

AED 315.00 RECEIPT VOUCHER (No.REC-005014) **Date:07-09-2019**

Receive from Mr./Mrs./M/s. **1001441 - AIHAM ABU HELWEH - 971505878706**

The sum of Dhs. **Three Hundred Fifteen Dirhams and Zero Fils Only**

By Cash **0.00** / By Credit Card **315.00** / By Cheque **0.00** / By Bank Transfer **0.00** / By Allocated **0.00**

Bank: Cheque No. Date: **07-09-2019**

Being **BRACES FOLLOW UP + VAT**

Made by **Rana**

1.Any Advance refund will be accepted within 48 hours for 25% of deduction from the total amount.
2.Treatment includes lab cost is non-refundable.
3.After 48 hours No refundable accepted

Confirmed by : **1001441 - AIHAM ABU HELWEH - 971505878706**

Tel : + 9716 555 8337, Fax : + 9716 528 8130, e – mail : info@omc1.ae
www.omc1.ae

مركز أوركيد الطبي
ORCHID MEDICAL CENTER

AED 315.00 **RECEIPT VOUCHER (No.REC-005794)** **Date:02-11-2019**

Receive from Mr./Mrs./M/s. **1001441 - AIHAM ABU HELWEH - 971505878706**

The sum of Dhs. **Three Hundred Fifteen Dirhams and Zero Fils Only**

By Cash **15.00** / By Credit Card **0.00** / By Cheque **0.00** / By Bank Transfer **0.00** / By Allocated **300.00**

Bank: Cheque No. Date: **02-11-2019**

Being **BRACES FOLLOW UP + VAT**

Made by **Rana**

1.Any Advance refund will be accepted within 48 hours for 25% of deduction from the total amount.
2.Treatment includes lab cost is non-refundable.
3.After 48 hours No refundable accepted

Confirmed by : **1001441 - AIHAM ABU HELWEH - 971505878706**

Tel : + 9716 555 8337, Fax : + 9716 528 8130, e – mail : info@omc1.ae
www.omc1.ae