مركز أوركيد الطبي
ORCHID MEDICAL CENTER

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

File No: 1001750

Date: 11 / 3 / 19

Date: ... / ... / ..... File Number: 1001750

Patient Name: Hiba Khamis ..... إسم المريض :

Date Of Birth (تاريخ الميلاد) 11 / 06 / 1987 Gender (الجنس) : M / (F) Marital Status:(الحالة الاجتماعية) Single

Nationality (الجنسية): Jordanian Occupation (الوظيفة) : sales

Address (العنوان) : Dubai / Nadif Phone No. (رقم الهاتف): 0563649376

E-MAIL: hibakhaireddin@hotmail.com How did you know about us: search engine google

Medical History التاريخ الطبي

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

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

انا على دراية تامة أن أي مدفوعات للمركز هي غير قابلة للاسترداد

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

التاريخ: 19 / 03 / 2011

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.

I am fully aware that any payments is NON refundable

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

Diagnosis التشخيص

File No: .....

Date: / /

Treatment Plan خطة العلاج

- she came to correct her smile via (Emax-veneers) - shape of teeth and size is not satisfying the patient.

- Needs some scalling & polishing.

Doctor's Signature and Stamp

Dr. Dalia

مركز أوركيد الطبي
ORCHID MEDICAL CENTER

PATIENT NAME: **FILE NO#:**

DATE	TREATMENT	PAYMENT	BALANCE	SIGNATURE
11/3/2019	Impression for Veneers (study cast Imp.) (9900 Dhs.) offer	5197.50		Dr. Dalia
11/3/19.	Laebow peel 3 steps done PT. Paid 3 session offer Remaining 2 session Carbon Peel	700		Reem
16/3/2019	- preparation of 20 tooth / Impression + Bite registration - Shade BL2			Dr. Dalia
23/3/2019	Cementation of 20 tooth veneeers.			Dr. Dalia
23/03/19.	Carbon Peel done.			
30/3/2019	Scaling & polishing For veneers & follow up			Dr. Dalia

مركز أوركيد الطبي
ORCHID MEDICAL CENTER

PATIENT NAME: **FILE NO#:**

DATE	TREATMENT	PAYMENT	BALANCE	SIGNATURE
20/4/19	Whitening Mask			
20/4/19	Cleaning Peel 3 Steps done			

د. وسام مروان الطباع
Dr. Wesam Marwan Al Tabbaa
اخصائي جلدية
Dermatology specialist
MOH License No.: V826 ترخيص رقم:
Orchid Medical Centre مركز اوركيد الطبي

REDAD DATA

cAEAIOEBAA83ODQxO

Public Data Readed Succ

SHOW READED DATA

Confirm Data

Public Data Verification report

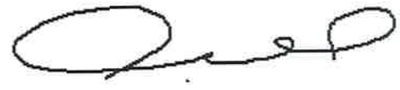
File	Valid Signature?
Non-Modifiable Data (SF3)	False
Modifiable Data (SF5)	False
Holder Signature Image (SF7)	False
Photography	False
Home Address	False
Work Address	False

Card Holder Information

Name	Hiba,Khamis,Ahmad,,Khaireddin	**IDN:**	784198782102929	**Mother Name:**	
Name (Ar)	هبه,خميس,احمد,,خير الدين	**Card Number:**	092005226	**Mother Name (Ar):**	
Title:		**Nationality:**	JOR	**Family ID:**	
Title (Ar):		**Nationality (Ar):**	الأردن		
Issue Date:	30/11/2018	**Sex:**	F	**Sponsor Type:**	06
Expiry Date:	27/11/2020	**Date of Birth:**	11/06/1987	**Sponsor Name:**	شركه بيان الطبيه ذ م م
Marital Status:	01	**Husband IDN:**		**Sponsor Number:**	00
Residency Type:	02	**Residency Number:**	20120182622252	**Residency Expiry:**	27/11/2020
ID Type:	IL	**Occupation:**	02	**Occupation Field:**	00

Photo

Signature Image



http://orchidsvr/EMID/default.aspx

3/11/2019

مركز أوركيد الطبي
ORCHID MEDICAL CENTER

No: REC-002937

AED 5,197.50

RECEIPT VOUCHER

Date: 11-03-2019

Receive from Mr./Mrs./M/s. **1001750 - HIBA KHAMIS - 971563649376**

The sum of Dhs. **Five Thousand One Hundred Ninety Seven and Five Fils Only**

By Cash **0.00** / By Credit Card **5,197.50 (Bank Charges: 0.00)** / By Cheque **0.00** / By Bank Transfer **0.00** / By Allocated **0.00**

Bank: Cheque No. Date:

.ing **ADVANCE FOR VENEER 5,197.5 (TOTAL 9900)**

Made by **Hiba**

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

مـركـــز أوركـــيـــد الـــطـــبـــي
ORCHID MEDICAL CENTER

AED 735.00

RECEIPT VOUCHER (No.REC-002938)

Date:11-03-2019

Receive from Mr./Mrs./M/s. **1001750 - HIBA KHAMIS - 971563649376**

The sum of Dhs. **Seven Hundred Thirty-Five Dirhams and Zero Fils Only**

By Cash **0.00** / By Credit Card **735.00** / By Cheque **0.00** / By Bank Transfer **0.00** / By Allocated **0.00**

Bank: Cheque No. Date: **11-03-2019**

Being **PT PAID 3 SESSION CARBON LASER + 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 : **1001750 - HIBA KHAMIS - 971563649376**

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

ORCHID MEDICAL CENTER

MODE OF PAYMENT RECEIVED FOR LAB PROCEDURE

NO: TEETH	RATE / TEETH	TOTAL AMT OF TREATMENT:	ADVANCE COLLECTED	CASH	CARD	CHEQUE	BALANCE
Veneers offer 20 Tooth		9900 + VAT	5197.50		✓		5197.50

BALANCE AMOUNT

INSTALLMENT DETAILS

BANK NAME	DT: CHQ	CHQ #	INSTALLMENT AMT	CHQ REPLACEMENT DETAILS
Noor bank	30-3-19	100004	866.25	
Noor bank	30-4-19	100008	866.25	
Noor bank	30-5-19	100009	866.25	
Noor bank	30-6-19	100007	866.25	
Noor bank	30-7-19	100006	866.25	
Noor bank	30-8-19	100005	866.25	
		TOTAL	5197.50	

Need to be Changed
24/03/2019.

CHQ COLLECTED FROM FRONT DESK: Rahman

NAME & SIGNATURE WITH DT : 23-3-19

NOOR BANK

100004

PERSONAL

SZR BRANCH

Date 30/3/2019

Pay to the order of Orchid Medical Center

UAE Dirhams Eight Hundred Sixty Six and Twinty Five only-

AED 866.25/-

HIBA KHAMIS AHMAD KHAIREDDIN
A/C # 00189408740018
IBAN # AE840520000189408740018

⑈100004⑈ ⑆905220106⑆ ⑈89408740018⑈

Done

Signature

NOOR BANK

100008

PERSONAL

SZR BRANCH

Date 30/4/2019

Pay to the order of Orchid Medical Center

UAE Dirhams Eight Hundred Sixty Six and Twenty Five Fils only.

AED 866.25/-

HIBA KHAMIS AHMAD KHAIREDDIN
A/C # 00189408740018
IBAN # AE840520000189408740018

⑈100008⑈ ⑆905220106⑆ ⑈89408740018⑈

Done

Signature

NOOR BANK

100009

PERSONAL

SZR BRANCH

Date 30/5/2019

Pay to the order of Orchid Medical Center

UAE Dirhams Eight Hundred Sixty Six and Twenty Five Fils only-

AED 866.25/-

HIBA KHAMIS AHMAD KHAIREDDIN
A/C # 00189408740018
IBAN # AE840520000189408740018

⑈100009⑈ ⑆905220106⑆ ⑈89408740018⑈

Done

Signature

100007

PERSONAL

NOOR BANK

SZR BRANCH

Date: 30/6/2019

Pay to the order of: Orchid Medical Center

UAE Dirhams: Eight Hundred Sixty Six and Twenty Five Fils Only

AED 866.25/-

HIBA KHAMIS AHMAD KHAIREDDIN
A/C # 00189408740018
IBAN # AE840520000189408740018

⑈100007⑆905220⑆⑈89408?400⑆

Signature

Done

100006

PERSONAL

NOOR BANK

SZR BRANCH

Date: 30/7/2019

Pay to the order of: Orchid Medical Center

UAE Dirhams: Eight Hundred Sixty Six and Twenty Five Fils Only

AED 866.25

HIBA KHAMIS AHMAD KHAIREDDIN
A/C # 00189408740018
IBAN # AE840520000189408740018

⑈100006⑆905220⑆⑈89408?400⑆

Signature

Done

100005

PERSONAL

NOOR BANK

SZR BRANCH

Date: 30/8/2019

Pay to the order of: Orchid Medical Center

UAE Dirhams: Eight Hundred Sixty Six and Twenty Five fils only

AED 866.25

HIBA KHAMIS AHMAD KHAIREDDIN
A/C # 00189408740018
IBAN # AE840520000189408740018

⑈100005⑆905220⑆⑈89408?400⑆

Signature

مركز أوركيد الطبي
ORCHID MEDICAL CENTER

Veneer Treatment Form **طلب تركيب فينير الاسنان**

Colour Been Chosen BL2 اللون الذي تم اختياره

Design Been Chosen Normal التصميم الذي تم اختياره

Quantity Agreed to Order 20 tooth العدد المتفق على تركيبه

Notes: ملاحظات أخرى:

I have red and agreed to the mentioned specifications above and Orchid Medical Center is not responsible of any change that not matching the above mentioned Specs.

لقد قرأت و أوافق على المواصفات التي تم الإشارة إليها في هذه الورقة و أخلي مسؤولية مركز اوركيد الطبي من أي تغيير لا يطابق المواصفات المشار اليها.

Patient Name: HIBA **اسم المريض:** هبة خير كيني

Date: 23 / 3 /2019 **التاريخ:** 2019 / /

Signature: **التوقيع:**

ORCHID MEDICAL CENTER

TREATMENT PLAN

PATIENT NAME	OMC FILE #	TREATMENT TYPE
Hiba Khamis	001750	Veneers offer 9900

TREATMENT PLAN	AMOUNT	NO: OF STEPS
- Scalling & polishing	Free	one step
- 20 tooth emax - veneers.	9900	two steps
TOTAL AMOUNT	9900 0	

Prepared By :

Dr. Dalia

5197/50 Advance Received on. 11/03/19

Balance - 5197/50. Received on. 6 PDC X 866/25

Full Payment Received. 25/03/19

مركز أوركيد الطبي
ORCHID MEDICAL CENTER

TAX INVOICE (NO. INV-C004015)

Patient File #	:	**1001750**	Visit Date	:	**23-03-2019**
Patient Name	:	**HIBA KHAMIS**	Insurance	:	**Cash**
Doctor	:	**DR.DALIA**	Invoice Date	:	**26-03-2019**
VAT Reg #	:	**100479302000003**			

Sl.No	Code	Service	Unit Price	Quantity	Gross	Discount	VAT %	VAT Amount	Net
1.	CPT036	Veneers (Per Unit)	495.00	20	9,900.00	0.00	5.00	495.00	9,900.00
		Gross Total (in AED)							**9,900.00**
		Discount (in AED)							**0.00**
		Net Total (in AED)							**9,900.00**
		VAT TOTAL							**495.00**
		NET + VAT TOTAL							**10,395.00**
		Balance (in AED)							**5,197.50**
		Advance Balance (in AED)							**0.00**

Prepared By Rana

20 TOOTH VENEER COMPLETED- 50% (5197.50 ADVANCE RECD) BALANCE 6 CHQ@ 866.25 EACH CHQ START FROM 30.03.19-30.08.19

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

مـركـــز أوركـــيـــد الـــطـــبـــي
ORCHID MEDICAL CENTER

AED 5,197.50 **RECEIPT VOUCHER (No.REC-003087)** **Date:26-03-2019**

Receive from Mr./Mrs./M/s. **1001750 - HIBA KHAMIS - 971563649376**

The sum of Dhs. **Five Thousand One Hundred Ninety-Seven Dirhams and Fifty Fils Only**

By Cash **0.00** / By Credit Card **0.00** / By Cheque **0.00** / By Bank Transfer **0.00** / By Allocated **5,197.50**

Bank: Cheque No. Date: **26-03-2019**

Being **20 TOOTH VENEER COMPLETED- 50% (5197.50 ADVANCE RECD) BALANCE 6 CHQ@ 866.25 EACH CHQ START FROM 30.03.19-30.08.19**

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 : **1001750 - HIBA KHAMIS - 971563649376**

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

مـركـــز أوركـــيـــد الـــطـــبـــي
ORCHID MEDICAL CENTER

AED 866.25

RECEIPT VOUCHER (No.REC-003129)

Date:30-03-2019

Receive from Mr./Mrs./M/s. **1001750 - HIBA KHAMIS - 971563649376**

The sum of Dhs. **Eight Hundred Sixty-Six Dirhams and Twenty-Five Fils Only**

By Cash **866.25** / By Credit Card **0.00** / By Cheque **0.00** / By Bank Transfer **0.00** / By Allocated **0.00**

Bank: Cheque No. Date: **30-03-2019**

Being **FIRST CHEQUE PAYMENT 866.25 AED REMAINING BALANCE 4331.25 AED**

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 : **1001750 - HIBA KHAMIS - 971563649376**

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

مركز أوركيد الطبي
ORCHID MEDICAL CENTER

AED 525.00 **RECEIPT VOUCHER (No.REC-003401)** **Date:20-04-2019**

Receive from Mr./Mrs./M/s. **1001750 - HIBA KHAMIS - 971563649376**

The sum of Dhs. **Five Hundred Twenty-Five Dirhams and Zero Fils Only**

By Cash **0.00** / By Credit Card **525.00** / By Cheque **0.00** / By Bank Transfer **0.00** / By Allocated **0.00**

Bank: Cheque No. Date: **20-04-2019**

Being **WHITENING MASK**

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 : **1001750 - HIBA KHAMIS - 971563649376**

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

مـركـز أوركـيـد الـطـبـي
ORCHID MEDICAL CENTER

AED 150.00 **RECEIPT VOUCHER (No.REC-004219)** **Date:27-06-2019**

Receive from Mr./Mrs./M/s. **1001750 - HIBA KHAMIS - 971563649376**

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

By Cash **0.00** / By Credit Card **150.00** / By Cheque **0.00** / By Bank Transfer **0.00** / By Allocated **0.00**

Bank: Cheque No. Date: **27-06-2019**

Being **Composite Filling 1 Surface**

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 : **1001750 - HIBA KHAMIS - 971563649376**

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

مركز أوركيد الطبي
ORCHID MEDICAL CENTER

AED 866.25 **RECEIPT VOUCHER (No.REC-005211)** **Date:26-09-2019**

Receive from Mr./Mrs./M/s. **1001750 - HIBA KHAMIS - 971563649376**

The sum of Dhs. **Eight Hundred Sixty-Six Dirhams and Twenty-Five Fils Only**

By Cash **0.00** / By Credit Card **0.00** / By Cheque **866.25** / By Bank Transfer **0.00** / By Allocated **0.00**

Bank: Cheque No. **100009** Date: **26-09-2019**

Being **PAYMENT FOR CHQ #100009 DATED ON 30-5-2019 NOOR BANK**

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 : **1001750 - HIBA KHAMIS - 971563649376**

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

مركز أوركيد الطبي
ORCHID MEDICAL CENTER

AED 866.25 **RECEIPT VOUCHER (No.REC-005210)** **Date:26-09-2019**

Receive from Mr./Mrs./M/s. **1001750 - HIBA KHAMIS - 971563649376**

The sum of Dhs. **Eight Hundred Sixty-Six Dirhams and Twenty-Five Fils Only**

By Cash **0.00** / By Credit Card **0.00** / By Cheque **866.25** / By Bank Transfer **0.00** / By Allocated **0.00**

Bank: Cheque No. **100008** Date: **26-09-2019**

Being **PAYMENT FOR CHQ #100008 DATED ON 30-4-2019 NOOR BANK**

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 : **1001750 - HIBA KHAMIS - 971563649376**

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