



**The International Center**  
**Children's Hospital Boston**  
 Tel: (617) 355-5209  
 Fax: (617) 730-0627

**IC Number:** 10965  
**Estimate Number:** 18418  
**Estimate Date:** 02/07/2008  
**Prepared By:** Kristaq Dhima

**Medical Services Cost Estimate**

**Name:** Georgi Borisov

**Diagnosis/Procedure** Short Boewl / Uper Endoscopy

Hospital Services		Estimated Fee
Miscell.Services @2800.00 but not limited per day		\$2,800.00
In-Patient		\$1,947.00
Recovery (2)		\$1,502.00
Anesthesia (2)		\$1,784.00
OR (2)		\$7,972.00
Pre-op		\$1,097.00
Endoscopy		\$4,987.00
		<b>\$22,089.00</b>

Physician Services		Estimated Fee
Children's Hospital Pediatric Ass	In-Patient visit	\$300.00
Children's Hospital Pediatric Ass	GI Consults (5)	\$3,560.00
Children's Hospital Pediatric Ass	Nutrition Consults (10)	\$7,120.00
CHMC Anesthesia Fnd.	Anesthesia Fee	\$2,601.00
CHMC Surgical Fnd.	Dr. Fee	\$2,000.00
Misc. Physician Consult Fee	.	\$2,500.00
		<b>\$18,081.00</b>

**Total Deposit Amount Required for Medical Services** **40,170.00**

**Notes**

*Payment of the above sum is required at least 5 business days prior to the patient's first appointment at Children's Hospital Boston. Failure to make this payment within 5 business days of the first appointment could result in a delay of the patient's care. Thank you!*

Please note: This estimate does not represent a package price, or the actual costs for diagnostic or medical care. The actual costs of care cannot be determined until services have been provided. It is the responsibility of each family to ensure that all medical services are paid in advance of service.

**Payment Instructions**

**Federal Express:**

Children's Hospital Boston  
300 Longwood Avenue  
Pavilion 119  
Boston, MA 02115  
USA

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**Checks:**

Make USD check payable to: Children's Hospital Boston  
Mailing Address:  
International Accounts  
P.O. Box 3633  
Boston, MA 02241-3633

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**Wire Transfer Routing Instructions:**

Bank Name: Bank of America  
Bank Address: 100 Federal Street, Boston, MA 02110  
ABA Number: 0260-0959-3\*  
\*(ABA number represents the electronic address of the bank)  
Bank Account Name: Children's Hospital International Account  
Bank Account Number: 27429930  
Attention: International Center/Telephone(617)355-5209  
Please include: **Patient Name:** Georgi Borisov  
**Patient Medical Record Number:**

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**Credit Card:**

We accept Visa, Master Card, American Express, Diner's Club.

Please complete the credit card authorization form:

I, \_\_\_\_\_ the undersigned, authorize Children's Hospital Boston to  
charge my credit card with the total amount of US\$ \_\_\_\_\_  
Credit Card Number: \_\_\_\_\_  
Expiration Date: \_\_\_\_\_  
Name as it appears on the card: \_\_\_\_\_  
Credit Card Billing Address: \_\_\_\_\_

Signature: \_\_\_\_\_

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**Should you have any questions regarding this estimate, please contact the International Center at (617) 355-5209**