NewYork-Presbyterian
The University Hospital of Columbia and Cornell

Inna Shurigina
Financial Supervisor
International services

NewYork-Presbyterian/Weill Cornell
525 East 68th Street, GP1 503
New York, NY 10065

TEL 212 746-4455
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Ins9010@nyp.org

February 10, 2011

The mission of New York – Presbyterian Hospital and the physicians of Columbia and Cornell is to provide excellence in patient care and service. On behalf of the International Department we would like to thank you for using our services and would like to take this opportunity to provide you with an estimate of charges for the care and treatment recommended by your physician. This estimate includes hospital charges as well as fees for the physicians associated with your care.

ESTIMATE OF CHARGES:

Your bill is divided in two main components:

Hospital: This is the "technical" component of your bill and may include items such as: hospital room, laboratory tests, operating room, medications, radiology and other diagnostic tests or procedures. You will also note a NYS Surcharge line item. This is a tax based on 9.63% of your overall hospital bill and is required by law.

Physicians: This is the "professional" component of your bill and reflects the fees of the physicians directly involved in your care as well as other physicians who interpret the results of laboratory or diagnostic tests. You may or may not consult with or even see these physicians but they are also part of the team of health care professionals who communicate the results of your tests to your attending physician. There is no tax on these fees.

The hospital policy requires that we collect the entire amount requested on this estimate prior to services being rendered. Payments can be made by wire transfers, check, cash or credit card. After your care at the hospital is complete, your bill will be finalized within 4-6 weeks and an Executive Summary with all your bills will be sent to you at that time. The total bill may vary from the estimate, depending upon your actual charges. If actual charges exceed the estimate, payment for the balance is expected within two weeks of receiving the final invoice. If the estimate exceeded the actual charges, any overpayment will be refunded to you promptly.

Please see attached Estimate of Charges.

Please contact us to make the necessary arrangements. The International Services Department is open Monday through Friday from 9:00 a.m. to 5:00 p.m. (Eastern Standard Time U.S.) and we can be reached as follows:

Telephone: (212) 746-4455
Fax: (212) 746-4777
Email: ins9010@nyp.org

Again, thank you for selecting New York – Presbyterian. Should you have any questions or comments, please don't hesitate to contact us.

Sincerely,

Inna Shurigina
Financial Supervisor

ESTIMATE OF CHARGES

2/10/2011

Patient Name: Nadezhda Chernoknizhnaya
Procedure: Orbitofrontal craniotomy for resection of tumor
Hospital Stay : 7 Days

Hospital Charges:		
Pre-Admiting Testing	**$**	**3,000.00**
Operating Room 6 Hours	**$**	**16,801.00**
Neuro ICU 2 days	**$**	**20,700.00**
Semi-private room 5 days	**$**	**25,000.00**
Ancillary charges	**$**	**15,000.00**
NYS 9.63% Surcharge:	**$**	**7,752.25**
Total Hospital Charges:	**$**	**88,253.25**
Total Professional Fees:		
Dr. Schwartz/ Dr. Souweidane's Fee	**$**	**80,000.00**
Anesthesiologist's Fee	**$**	**7,500.00**
ICU Physician's Fee	**$**	**3,000.00**
Pathologist's Fee	**$**	**5,000.00**
Radiologist's Fee	**$**	**7,000.00**
ECG Associates	**$**	**500.00**
Total Professionals Fee:	**$**	**103,000.00**
Total Estimated Charges and Fees:	**$**	**191,253.25**

Ths is only an estimate and does not include cost associated with any complications, other physicians, need for additional hospitalization, tests or radiology studies

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USA

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internationalservices@nyp.org
http://nyp.org/international/

PAYMENT OPTIONS AND INSTRUCTIONS

1. Wire Transfer:

NewYork-Presbyterian The University Hospital of Columbia and Cornell		Weill Cornell Medical College	
Account Name	**"Citibank Operating for New York Hospital**	**Account Name**	**Weill Cornell Medical College**
Bank	**Citibank New York 666 Fifth Avenue New York, NY 10103 USA**	**Bank**	**Chase Bank 360 East 72nd Street New York, NY 10021 USA**
Account No.	**83152260**	**Account No.**	**12-6005745**
ABA No.	**02100089**	**ABA No.**	**02100021**
Swift No.	**CitiUS33**	**Swift No.**	**CHASUS33**
Patient Name		**Patient Name**	
Amount	**USD**	**Amount**	**USD**

Please fax confirmation of wire transfer with date of transfer and amount transferred to +1-212-746-4777

2. Credit Card:

o Visa o MasterCard o American Express

__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__
Card number

_____ USD _____
Expiration Date mm / yy Amount

_____ _____
Cardholder name (Print) Patient's Name (please print)

_____
Cardholder signature

I hereby authorize The New York and Presbyterian Hospital to charge my credit card for the amount indicated above.

See Page 4 for check information:

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3. Check Information:

Payment via check must be either a US certified bank check or traveler's check. Please provide two separate checks payable as shown below:

a. Hospital Charges: One check payable to NewYork-Presbyterian Hospital for USD _____
b. Professional Charges: One check payable to Weill Cornell Medical College for USD _____