

Room 1725A, 17 th floor, phase I, The Grand Plaza Mong Kok, Kowloon Tel: 23532180 Fax 2352 2666

Hong Kong Endoscopy Centre

**Account Opening Form**

Doctor Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Chinese\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

**Endoscopy Privilege to any private hospital in Hong Kong:**

OGD\_\_\_\_\_\_\_Colonoscopy\_\_\_\_\_\_ Cystoscopy\_\_\_\_\_\_ ESD\_\_\_\_\_\_ EUS\_\_\_\_\_\_ (please tick)

Which Hospitals? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Certificate copies attached: A.P.C\_\_\_\_\_\_\_\_ M.P.S\_\_\_\_\_\_\_\_\_ Specialty: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Use company name on bill? \_\_ Y \_\_\_\_N Company Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Business Registration Number: (if any)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clinic Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tel No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Emergency contact mobile No.:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact person for billing matters: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tel No.:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Billing or A/C Dept. address (if different to clinic address):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The Doctor agreed to pay the Centre within 30 days of the invoice by cheque or by bank deposit:

1/ By Cheque:

Cheque payable to **“Hong Kong Endoscopy Centre**”

2/ Bank Deposit: Name of Bank: **Bank of China (Hong Kong) Limited**

Account Name: **Hong Kong Endoscopy Centre**

Account Number: **012-586-00105471**

Doctor’s Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Please complete and return this form, with your name card and a copy of your certificates of Business registration, Medical Protection Society and Annual Practicing Certificate to the Centre by mail or fax.*