Southern Cross Hospitals

Patient admission form

IMPORTANT: Please send this completed form to the Hospital where you will have your procedure/surgery.

PERSONAL AND ADMINISTRATION DETAILS

Surname (family name): _____ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Mstr ☐ Dr ☐

First name(s): _____ **Preferred name:** _____

Date of birth: ____ (d) / ____ (m) / ____ (y) **Gender:** Male ☐ Female ☐ **NHI:** _____

Residential address: _____

Postal address: _____

Email address: _____

Telephone: (Home) _____ (Business) _____ (Mobile) _____

New Zealand resident: Yes ☐ No ☐ If No, you are required to complete an 'Acknowledgement Form: Non NZ Resident'

Ethnicity: European / Māori / Pacific Island / Asian / Middle Eastern / Latin American / African / Other _____
(Please circle one or more)

General Practitioner: _____ **Telephone:** _____

NEXT OF KIN/CONTACT PERSON

Name: _____ **Relationship to patient:** _____

Address: _____

Telephone: (Home) _____ (Business) _____ (Mobile) _____

PAYMENT DETAILS

How will your procedure be paid for? Tick and complete as many as applies:

☐ **Health insurance** (personal expenses such as telephone calls may be excluded)

Insurance details: _____ Membership No: _____

Have you obtained "prior approval" for payment? Yes ☐ No ☐ Approval No: _____

☐ **ACC** (personal expenses such as telephone calls are excluded) ☐ **DHB** (personal expenses such as telephone calls are excluded)

☐ **Paid personally** If you are paying for all of the costs you will be asked to pay the estimated cost of your Hospital account on or before admission. The balance of your account must be settled on discharge.

ACCOUNT SETTLEMENT AND CREDIT CARD AUTHORISATION

I will pay my account by: Cheque ☐ Cash ☐ Credit card ☐ Eftpos ☐

If you select credit card as your payment option, please complete and sign:

Card type: MasterCard ☐ Visa ☐ Diners ☐ AMEX ☐

Credit card number: ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ Expiry date: ____ (m) / ____ (y)

Name on credit card: _____ Signature: _____

I understand that signing this Credit Card Authority authorises Southern Cross Hospital to debit my credit card with all amounts due and owing to Southern Cross Hospital in relation to my admission and treatment at Southern Cross Hospital on date: ____ (d) / ____ (m) / ____ (y)

AGREEMENT

I agree to settle my Hospital account in full when personally paying my account or where I do not have "prior approval" from my insurer. I understand I will be required to pay the estimated cost of my Hospital account on or before admission to Hospital. I understand I am responsible for any outstanding balance if my procedure is not fully covered by insurance, ACC or other contract. I give permission for Southern Cross to obtain any information relating to the approval/claim for this admission from the relevant funder/s, and I authorise that person or organisation to disclose such information to Southern Cross Hospital. I accept that, in the event my Hospital account is not met, Southern Cross reserves the right to add all costs of collection to this account. I give permission to Southern Cross Hospital or any health professional involved in my care for this admission to Hospital, to access health information about me that is relevant to my current treatment, which may be held by Southern Cross, other health professionals or other health organisations. I understand that other clinical team members such as student nurses and qualified medical trainees may have supervised involvement with my care and that I have the right to decline their presence or contribution to my care delivery. I understand the admitting Surgeon, Anaesthetist and other Doctors or health professionals using Southern Cross facilities are independent and not employees of Southern Cross, with respect to both my treatment, care and account payment. I accept that this agreement is covered by New Zealand law. The details above have been completed by:

Name: _____ Date: ____ (d) / ____ (m) / ____ (y)

Signature: _____ If not the patient, state relationship to patient: _____