GILLIES
A SOUTHERN CROSS HOSPITAL

FORM 2
PATIENT ADMISSION FORM

Return all forms to arrive at Gillies Hospital at least ONE WEEK before admission

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 ☐ I identify my gender as _____

Residential address: _____ **NHI:** (if known) _____

Postal address: _____

NZ Address if visiting from overseas: _____

Email address: _____

Telephone: Home _____ Work _____ Mobile _____

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

Ethnicity: ☐ NZ / European ☐ Māori ☐ Pacific Island ☐ Asian ☐ Middle Eastern ☐ Latin American ☐ African ☐ Other _____

General Practitioner name: _____ **Telephone:** _____

Medical Centre: _____

NEXT OF KIN / CONTACT PERSON **Name:** _____ **Relationship to patient:** _____

Address: _____

Telephone: Home _____ Work _____ Mobile _____

Payment Details

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

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

Insurance Company: _____ Policy No: _____

Have you obtained "prior approval" for payment? Yes ☐ No ☐ Approval No: _____ (if known)
Copy of approval letter required by admission date

Southern Cross Affiliated Provider contract ☐

☐ **Contract: e.g. ACC / DHB / Cochlear** (personal expenses such as telephone calls are excluded)

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

ACCOUNT SETTLEMENT

I will pay my account by: EFTPOS ☐ Credit card ☐ Debit Card ☐ Internet Banking ☐ Cheque ☐

For Internet Banking:

Payee: Southern Cross Hospitals Ltd **Bank a/c:** 12-3113-0126623-00

Particulars: Patient Name **Code:** Date of Surgery e.g. 12 Sep 2019 **Reference:** Gillies

Go to **www.southerncrosshospitals.co.nz** for the online payment option (using a credit card)

Agreement

I agree to settle my hospital account in full at the time of my discharge 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 prior to admission to Gillies 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 Gillies Hospital 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 Gillies Hospital. I accept that, in the event my hospital account is not met, Gillies Hospital reserves the right to add all costs of collection to this account. I understand the admitting surgeon, anaesthetist and other doctors or health professionals using Gillies Hospital facilities are independent and not employees of Gillies Hospital 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 the relationship to patient: _____