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 ☐

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 are excluded)

Name of Insurer: _____

Insurance Plan Name: _____ 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 the procedure yourself, you may be asked to pay an estimated deposit before admission. The balance of your account must be settled on discharge.

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

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 2014 Reference: Hospital e.g. Hamilton

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 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 Hospitals 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 Hospitals. I accept that, in the event my Hospital account is not met, Southern Cross Hospitals reserves the right to add all costs of collection to this account.

I give permission to Southern Cross Hospitals 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 Hospitals, 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 Hospitals facilities are independent and not employees of Southern Cross Hospitals, 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:** _____