NORTH SHORE SURGICAL CENTRE

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: ____ /____ /____ (dd / mm / yyyy) **NHI:** _____

Gender: ☐ Male ☐ Female ☐ I identify my gender as _____

Residential address: _____

Postal address: _____

Email address: _____

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

New Zealand resident: Yes ☐ No ☐ *If No, complete the 'Acknowledgement Form: Non-NZ resident' (on our website).*

Which ethnic group do you belong to? *Tick the box or boxes which apply to you.*

☐ New Zealand European ☐ Māori ☐ Samoan ☐ Cook Island Māori ☐ Tongan ☐ Niuean ☐ Chinese ☐ Indian

☐ Other *(such as Dutch, Japanese, Tokelauan) Please state:* _____

General Practitioner (Name): _____ **Telephone:** _____

Medical Centre: _____

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** ☐ **ACC** ☐ **DHB** ☐ **Paid personally** ☐ **Other** .....

Details of health insurance ☐ Southern Cross Affiliated Provider contract

Name of Insurer: _____

Insurance Plan Name: _____ Membership No: _____

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

(Provide your prior approval letter in advance)

Additional charges

Depending on your health insurance policy or plan you may be required to pay an excess (co-payment). You may also be required to pay for some charges that are not covered by insurance, ACC or DHB.

Payment prior to surgery

You may be asked to pay a deposit before admission. The amount is based on the estimated cost of the procedure payable by you not otherwise covered by your insurance, ACC or DHB. The deposit will be refunded to you if the procedure is cancelled.

Methods of payment

We accept payment by EFTPOS, VISA, Mastercard, UnionPay or internet banking. Personal cheques are not accepted. We prefer not to receive payment by cash.

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

Internet banking details

Payee: North Shore Surgical Centre **Bank a/c:** 12-3244-0009208-00

Particulars: Patient Name **Code:** Date of Surgery e.g. 12 Sep 2020 **Reference:** NSSC

Would you like to receive your invoice via email? ☐ YES ☐ NO

We will send the invoice to the email address you have provided above.

Please complete the agreement section on the reverse of this page.

NORTH SHORE
SURGICAL CENTRE

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

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 North Shore Surgical Centre 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 North Shore Surgical Centre. I accept that, in the event my hospital account is not met, North Shore Centre Centre reserves the right to add all costs of collection to this account.

I give permission to North Shore Surgical Centre or any health professional (such as my medical specialist) involved in my care in relation to this admission to hospital, to access health information about me that is relevant to my treatment (including pre-admission and after discharge), which may be held by North Shore Surgical Centre, 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 North Shore Surgical Centre facilities are independent and not employees of North Shore Surgical Centre, 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:** _____ / _____ / _____
dd mm yyyy

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