Southern Cross Healthcare

# 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 / Maori / 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)

☐ **Paid personally** If you are paying for the procedure yourself, please note that some procedures may require a deposit before admission. Your Surgeon's rooms or Hospital may inform you if a deposit applies.

### 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 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 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 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: _____