GILLIES HOSPITAL

A Surgical Group Ltd & Southern Cross Hospitals Partnership

FORM 2

PATIENT ADMISSION FORM

Return all forms to 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 ☐ NHI: (if known) _____

Residential address: _____

Postal address: _____

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)

NZ Address if visiting from overseas: _____

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

General Practitioner: _____ Telephone: _____

Surgeon: _____

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 may be excluded)

Insurance Company: _____ Policy No: _____

Have you obtained "prior approval" for payment? Yes ☐ No ☐ Approval No: _____ (if known)

Southern Cross Affiliated Provider contract ☐ Copy of approval letter required by admission date

☐ **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 AND CREDIT CARD AUTHORISATION

I will pay my account by: Cheque ☐ Cash ☐ Credit card ☐ Eftpos ☐ (bank daily limits may apply)

If you select credit card as your payment option, please complete and sign. **Card type:** MasterCard ☐ Visa ☐ Diners ☐ AMEX ☐

Credit card number: ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ Expiry date: _____ / _____

Name on credit card: _____ Signature: _____

I understand that signing this Credit Card Authority authorises Gillies Hospital to debit my credit card with all amounts due and owing to Gillies Hospital in relation to this admission and treatment at Gillies Hospital.

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 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: _____