



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

Admission details (if unsure of these details please contact your specialist)

Admission date: ____ / ____ / ____ Admission time: _____ Procedure/Surgery date: ____ / ____ / ____
dd mm yyyy (If different to admission date) dd mm yyyy

Day stay unit Day inpatient Overnight inpatient Anticipated length of stay _____ hours / days / nights

Sedation: Yes No Anaesthesia: Yes No Proposed anaesthesia: general / local / regional / spinal / epidural
(Please circle)

Personal and administration details

Surname (family name): _____ Mr Mrs Ms Miss Mstr Mx Dr

First name(s): _____ **Preferred name:** _____

Date of birth: ____ / ____ / ____ **NHI:** _____
dd mm yyyy

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) _____

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



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

Payment details

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

Health insurance **ACC** **Te Whatu Ora - Health NZ** **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: _____

Additional charges

(Provide your prior approval letter in advance)

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 such as visitor meals that are not covered by insurance, ACC or Te Whatu Ora - Health NZ.

Payment prior to surgery

You may be asked to pay a deposit 3-5 days before admission. The amount is based on the estimated cost of the procedure payable by you not otherwise covered by your insurance, ACC or Te Whatu Ora - Health NZ. The deposit will be refunded to you if the procedure is cancelled.

Methods of payment

We accept payment by EFTPOS, VISA, Mastercard, internet banking or online at our website www.southerncrosscentrallakeshospital.co.nz. 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: Southern Cross Central Lakes Hospital

Bank a/c: 12-3113-0131692-00

Particulars: Patient Surname

Code: Date of surgery (e.g. 14 Feb 2022)

Reference: Invoice No. (if known)

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

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

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

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

dd mm yyyy

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

Hospital (where you will have your surgery/procedure): _____

Please send your completed forms to the hospital where you have your surgery/procedure. If you do not yet have confirmation of the hospital where you will be admitted, please contact your specialist's practice to check the information required.