

Patient Admission Form

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

Surname (family name):	Mr Mrs Ms Miss Mstr Dr
First name(s):	Preferred name:
Date of birth: / /	NHI:
Gender: Male Female I identify my gender as	
Residential address:	
Postal address:	
Email address:	
Telephone: (Home) (Business)	
New Zealand resident: Yes No If No, complete the 'Acknow	
Which ethnic group do you belong to? Tick the box or boxes whic New Zealand European Māori Samoan Cook Island Māo Other (such as Dutch, Japanese, Tokelauan) Please state:	ori 🗆 Tongan 🗆 Niuean 🗆 Chinese 🗆 Indian
Medical Centre:	·
NEXT OF KIN/CONTACT PERSON	
	elationship to patient:
Address:	
Telephone: (Home) (Business)	(Mobile)
PAYMENT DETAILS	
How will your procedure be paid for? Tick and complete as many a	s applies:
□ Health insurance □ ACC □ DHB	
□ Health insurance □ ACC □ DHB	□ Paid personally □ Other
Details of health insurance Southern Cross Affiliate	ed Provider contract
Details of health insurance	ed Provider contract
Details of health insurance Southern Cross Affiliate Name of Insurer: Insurance Plan Name:	ed Provider contract Membership No:
Details of health insurance	ed Provider contract Membership No:
Details of health insurance Southern Cross Affiliate Name of Insurer: Insurance Plan Name:	ed Provider contract Membership No:
Details of health insurance □ Southern Cross Affiliate Name of Insurer:	ed Provider contract Membership No:
Details of health insurance Southern Cross Affiliate Name of Insurer: Insurance Plan Name: Insurance Plan Name: Have you obtained "prior approval" for payment? Yes No E Additional charges Depending on your health insurance policy or plan you may be req You may also be required to pay for some charges such as visitor means be required to pay a deposit 3-5 days before admission. The payable by you not otherwise covered by your insurance, ACC or Decancelled. Methods of payment We accept payment by EFTPOS, VISA, Mastercard, internet bankin www.southerncrosscentrallakeshospital.co.nz. Personal cheques	ed Provider contract Membership No:
Details of health insurance Southern Cross Affiliate Name of Insurer: Insurance Plan Name: Have you obtained "prior approval" for payment? Yes D No D Additional charges Depending on your health insurance policy or plan you may be required to pay for some charges such as visitor m Payment prior to surgery You may be asked to pay a deposit 3-5 days before admission. The payable by you not otherwise covered by your insurance, ACC or D cancelled. Methods of payment We accept payment by EFTPOS, VISA, Mastercard, internet bankir	ed Provider contract Membership No:
Details of health insurance Southern Cross Affiliated Name of Insurer:	Approval No:

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



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 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	уууу
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 well in advance of your surgery/procedure. If you do not yet have confirmation from the hospital regarding your admission there, please contact your specialist's practice to check the information required.