Admission Form

BOWEN HOSPITAL

Important!

Please deliver, post, fax or email this form 7–10 working days before your admission together with the completed Health Questionnaire and Consent Form to:

Bowen Hospital
98 Churchill Drive
Crofton Downs
Wellington 6035

A stamped, addressed envelope is provided

Fax (04) 479 8520
Email admissions@bowen.co.nz

If this is not possible, please make sure you bring the forms with you when you arrive for admission.
If you faxed or emailed the forms to us, please bring the originals with you.

Personal Details (patient to complete)

Admission Date:

Patient name:

Mr/Ms/Mrs/Miss/Dr

Surname *Given names*

Preferred Name *Known as* Date of birth Age NHI No

Previous Surname *If applicable* Ethnicity

Address

Postcode

Billing Address *(if different to above)*

Telephone *Home* *Work* *Mobile*

Email

Next of kin/contact person during my hospital stay:

Mr/Ms/Mrs/Miss/Dr

Relationship to patient

Address

Telephone *Home* *Work* *Mobile*

Patient's GP:

Name

Clinic Name/Address

Name of your Surgeon/ Physician admitting you to Bowen:

Please turn over to complete Payment Details and Agreement

Payment Details (patient to complete)

This section outlines the estimated fees for your procedure and your agreement to pay in full.

Method of Payment (please indicate how your treatment and care will be paid for and complete the relevant section(s) below)

☐ ACC ☐ Medical insurance ☐ Paying personally ☐ Other (eg. DHB Contract) _____

A ACC (Accident Compensation Corporation)

Claim No. _____ ACC Purchase Order No. _____

Paid under ACC co-payment ☐ Yes (complete section B and/or C for balance of payment) ☐ No

B Medical Insurance

Name of Insurer _____

Membership No. _____

Have you obtained prior approval for payment? ☐ Yes ☐ No

Approval No. _____ Affiliated Provider Scheme (APS) ☐

If not fully covered by medical insurance, or if no prior approval has been obtained, complete section C for balance of payment.

C Paying Personally

If you are uninsured and this procedure is not covered by any other funders, then you agree to prepay an account estimation supplied by Bowen Hospital at the time of admission. The hospital will inform you if this applies.

Account Payment and Credit Card Authorisation

I will pay my account by: ☐ Bank cheque ☐ Cash ☐ Credit card ☐ Eftpos ☐ Q Card

☐ Internet banking Payee: Bowen Hospital ASB A/c: 12-3244-0037479-00 Reference: Patient Name Code: NHI Number (as on estimate)

Type of Credit Card: ☐ MasterCard ☐ Visa ☐ AMEX

Credit Card No. ____ / ____ / ____ / ____

Name on Credit Card _____ Expiry date ____ / ____

I understand that signing this credit card authority authorises Bowen Hospital to debit my credit card with all outstanding amounts due and owing to Bowen Hospital in relation to my admission and treatment.

Signature _____

Agreement (patient to complete and sign prior to admission)

I have been advised that the estimate for the hospital charges (excluding surgeon, anaesthetist or other third party charges) is: $ _____

I understand additional costs due to the particular nature of my treatment and any complications may not have been included in the above estimate and may incur extra costs.

I understand that some costs such as laboratory testing, transfer and/or ambulance costs and other specialist costs such as radiology may not be covered by medical insurance and that these will be billed separately and will be payable by me. Included in your account may be a fee for Occupational Therapy services which may not be covered under my insurance policy.

I understand that if **I do not** have medical insurance or prior approval from my insurer, I agree to pay an estimated account on, or prior to admission, and settle my account in full on discharge. If the estimation results in any over-payment by me, Bowen Hospital will refund the amount to me.

I understand that I am personally responsible for any other costs associated with my procedure if it is not covered by medical insurance, ACC or any other funder.

I understand that the admitting specialist and anaesthetist using Bowen Hospital facilities are independent practitioners who are not employees of Bowen Hospital. I understand I have a direct relationship with them in respect to treatment, care and payment of their accounts.

I give permission for Bowen Hospital to obtain any information relating to the approval/claim for this admission from the funder, and I authorise disclosure of such information to and from that funder as deemed necessary to settle any claims.

Bowen Hospital reserves the right to add collection costs and interest as per its Terms of Trade to any overdue account.

Patient/Guardian Signature _____ Date _____