

Admission Form

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

Date of birth

Age

NHI No

Known as

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:**

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

Internet banking

Payee: Bowen Hospital
BNZ A/c: 02-0108-0418759-002

Reference: Patient Name
Code: NHI Number

(as on estimate)

Type of Credit Card: MasterCard Visa

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