Admission Form

BOWEN HOSPITAL

Important!

Please deliver, post 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

Email: admissions@bowen.co.nz

A stamped, addressed envelope is provided for posting.
If this is not possible, please make sure you bring the forms with you when you arrive for admission. If you emailed the forms to us, please bring the originals with you.

Admitting practitioner:

Admisson date:

Personal Details (patient to complete)

Personal details:

Mr/Ms/Mrs/Miss/Dr

First name *Middle name* *Surname*

Preferred Name *Known as* Date of birth Age NHI No: *If known*

Gender Ethnicity Are you: NZ Citizen Permanent resident

Email

Telephone *Home* *Work* *Mobile*

Address:

Postcode

Billing Address:

Postcode

GP Information:

Medical Centre or Clinic

GP's name Prefer not to say

Contact person during stay:

Mr/Ms/Mrs/Miss/Dr

Relationship to patient

Address

Telephone *Home* *Work* *Mobile*

How best to contact you:

How to contact you When is the best time for you to receive calls from our staff?

Are you happy for us to leave a message on an answer phone? Yes No

Are you happy for us to leave a message with a person? Yes No If so, who?

Continued over

Dietary needs:

The preassessment nurse will ask you for more information on any dietary requirements you may have.

Please indicate any dietary requirements:

Gluten free ☐ Dairy free ☐ Lactose free ☐ Pescatarian ☐ Vegetarian ☐ Vegan ☐ Keto ☐

FOD map ☐ Other

Allergies/intolerances

Payment and Insurance Details (patient to complete)

Please tick the relevant box for the funder of your procedure and complete all relevant section(s). If you do not know the information, please submit your forms and a representative from our hospital will be in touch.

ACC (Accident Compensation Corporation) ☐ Medical insurance ☐ Other ☐ Paying personally ☐

ACC

Claim number: *(If unknown, our staff will be happy to chase this information.)*

Medical Insurance

Name of insurer:

Have you obtained prior approval for payment? Yes ☐ No ☐ **If yes**, Approval number:

If no: If you are uninsured and this procedure is not covered by any other funders, then you agree to prepay an account estimation supplied by the hospital.

Other DHB Contract

Details:

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 the hospital prior to admission. Please sign and complete the payment agreement below

The hospital will send you a letter detailing how you can make payment via a debit card, credit card or bank transfer.

Agreement (patient to complete and sign prior to admission)

1. I understand that if I do not have full cover medical insurance or prior approval from my insurer, I agree to pay a co-payment/estimated amount prior to admission. This will be provided to me by the Hospital on request.
2. I understand that some costs such as laboratory testing, transfer and/or ambulance costs and other specialist costs such as radiology and occupational therapy will be billed separately and may be payable by me.
3. I understand that the admitting practitioner and anaesthetist using the Hospital facilities are independent practitioners who are not employees of the Hospital. I understand I have a direct relationship with them in respect to treatment care and payment of their accounts.
4. I give permission for the 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 claim.
5. The Hospital reserves the right to add collection costs and interest as per its terms of trade.

Please sign your name in the signature box to indicate your approval of the information provided. We will also verify this information with you in person on the day of admission.

Signature: **Date:**