

## Important!

Please deliver, post, fax or email this form 7-10 working days before your admission to:

**Royston Hospital**  
**500 Southland Road**  
**Hastings 4122**  
**Fax (06) 873 1189**  
**Email hospital@royston.co.nz**

} A stamped, addressed envelope is provided

If you faxed or emailed the forms to us, please bring the originals with you.

Admission Date

Admitting Practitioner

## Personal Details (patient to complete)

### Patient Name

Mr/Mrs/Ms/Miss/Dr

*Surname*

*Given Names*

Preferred Name

Date of Birth

Age

NHI No.

*Known as*

Previous Surname

Ethnicity

*If applicable*

Address

Postcode:

Billing Address (if different to above)

Telephone




*Home*

*Work*

*Mobile*

Email

Year of last Royston Hospital admission

### Next of Kin / Contact Person during my hospital stay

Mr/Mrs/Ms/Miss/Dr

Relationship to Patient

Address



Telephone




*Home*

*Work*

*Mobile*

### Patient's GP

Name

Clinic Name / Address

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.

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 or this procedure is not fully covered by any other funders, then you agree to prepay an account estimation supplied by Royston Hospital at the time of your admission. The hospital will inform you if this applies.

#### Account Payment and Credit Card Authorisation

I will pay my account by:  Internet Banking: Payee: Wakefield Health Ltd. Bank A/c: 02-0644-0128018-000.

Reference: Patient Name. Code: Patient Date of Birth

Bank Cheque  Cash  Eftpos  Credit Card

#### If paying by Credit Card, please complete and sign:

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 Royston Hospital to debit my credit card with the estimated amount 24 hours prior to surgery and any other outstanding amounts due and owing to Royston 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 and occupational therapy may not be covered by medical insurance and that these will be billed separately and will be payable by me.
- 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 overpayment by me, Royston 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 practitioner and anaesthetist using Royston Hospital facilities are independent practitioners who are not employees of Royston Hospital. I understand I have a direct relationship with them in respect to treatment, care and payment of their accounts.
- I give permission for Royston 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.
- Royston Hospital reserves the right to add collection costs and interest as per its Terms of Trade to any overdue account.

Patient/Gaurdian signature

Signature

Date

Date