PATIENT REGISTRATION FORM
ASCOT HOSPITAL

MercyAscot
GREENLANE + EPSOM + TAKAPUNA

PLEASE RETURN THIS FORM TO ASCOT HOSPITAL **AT LEAST ONE WEEK** PRIOR TO YOUR OPERATION/PROCEDURE DATE

YOUR DETAILS (to be completed by patient)

Title (please circle): Mr Mrs Ms Miss Dr Other

Gender: Male ☐ Female ☐

Legal First Name(s):

Date of Birth: / /

Family Name:

Marital Status:

Previous Name:

Occupation:

Country of Birth:

NZ Resident: Yes ☐ No ☐

NHI No: (if known)

Residential Address:

Postal Address (if different from above):

Phone: Home ( ) Work ( ) Mobile ( )

Email:

Ethnic Group:

Language Spoken:

Interpreter Required: Yes ☐ No ☐

Interpreter services must be arranged through your surgeon's rooms prior to admission

If visiting from overseas what is your address while staying in NZ?

Phone: ( )

EMERGENCY CONTACT PERSON

Name:

Gender: Male ☐ Female ☐

Relationship to Patient:

Residential Address:

Phone: Home ( ) Work ( ) Mobile ( )

HEALTH INSURER

Name of Insurer:

Policy Type:

Membership No:

Prior Approval No:

Is your surgery covered by ACC: Yes ☐ No ☐

ACC Approval Granted: Yes ☐ No ☐

ACC Claim No:

ACC Office:

ACC Case Manager:

FAMILY DOCTOR

Name:

Practice:

REFERRING MEDICAL PRACTITIONER

(IF DIFFERENT FROM FAMILY DOCTOR)

Name:

Practice:

SURGEON/SPECIALIST

Name:

Date of Admission: / /

Time of Admission:

PRESCRIPTION CARDS

☐ High Use Health Card Expiry Date: /

☐ Prescription Subsidy Card Expiry Date: /

☐ Community Services Card Expiry Date: /

☐ Other Expiry Date: /

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IF FAXING OR SCANNING SEND BOTH SIDES.

ACC CLAIMS

Contract Claim:

If your medical operation/procedure is an ACC Contract Claim, ACC will pay the hospital directly for all hospital and specialist's costs excluding personal expenses. Personal expenses, such as toll calls, drinks trolley beverages and visitor meals are required to be paid for on discharge.

Individual Claim:

If your medical operation/procedure is an individual ACC Claim, a copy of the ACC Letter of Approval **must** be received by Customer Support prior to Admission. **ACC does not cover full costs of hospitalisation.** A payment will be required on admission for the estimated difference.

Part ACC/Part Insurance:

Proof of prior approval is required on admission for the portion of your procedure that is covered by insurance. If you are not insured, you will be required to pay a portion of the estimated hospital costs on admission. For further details on ACC reimbursement practices please ask your ACC case manager.

PAYMENT OF HOSPITAL COSTS

For further information please refer to the Patient Information booklet

Payment will be made by ☐ credit card ☐ bank cheque ☐ cash ☐ EFTPOS ☐ other*

* Personal cheques are accepted by prior arrangement only. Personal cheques must be deposited **five** clear working days prior to admission to the hospital to allow for clearance.

- If you have no insurance you will be required to pay the full estimated cost of the operation/procedure **on admission**
- We strongly recommend you contact our Customer Support Team 09 520 9500 extn. 69134 for an estimate of the hospital costs prior to admission
- You understand and give consent that relevant information may be supplied to an external credit reporting agency to obtain a credit report
- You agree you are responsible and will pay for all costs incurred in connection with your treatment
- You understand that MercyAscot may notify a credit reporting agency and/or instruct a debt collection agency should you default on any payment due by you to MercyAscot
- You understand that any collection and/or legal costs incurred in recovering any debt will be charged to you

PERSONAL PROPERTY

- You understand and agree that MercyAscot is not and will not be responsible for loss of or damage to any personal property (including jewellery, dentures, watches, rings, glasses) which you may bring into the hospital
- You consent to MercyAscot sharing relevant information that is related to your healthcare and as required by third parties such as Health Insurers, Medical Specialists, ACC, and for quality and audit purposes

To the best of your knowledge the information you have supplied to MercyAscot is correct.

Signature: _____

Print Name (in full:) _____ Date: ____ / ____ / ____

PLEASE RETURN THIS FORM TO ASCOT HOSPITAL **AT LEAST ONE WEEK** PRIOR TO YOUR OPERATION/PROCEDURE DATE
(customersupport.ascot@mercyascot.co.nz or SEE PAGE 4 OF PATIENT INFORMATION BOOKLET)

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