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

PATIENT REGISTRATION FORM
HE PUKA RĒHITA TŪRORO

Kākāriki Hospital

YOUR DETAILS (to be completed by patient)

Title: ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr Other: | What was your sex at birth? M ☐ F ☐

Legal First Name(s): | What is your gender?

Family Name: | Date of Birth: / /

Previous Name: | Occupation:

County 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 specialist's rooms prior to admission

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

Phone:

EMERGENCY CONTACT PERSON

Name: | Gender:

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:

GENERAL PRACTITIONER

Name:

Practice:

REFERRING MEDICAL PRACTITIONER (If different from GP)

Name:

Practice:

Name: | Date of Admission: | Time of Admission:

☐ High Use Health Card Expiry Date: /

☐ Prescription Subsidy Card Expiry Date: /

☐ Community Services Card Expiry Date: /

☐ Other Expiry Date: /

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 visitor meals, will be invoiced directly to patients post-discharge.

Part ACC/Part Insurance:

Proof of prior approval is required prior or on admission for the portion of your procedure that is covered by insurance. For further details on ACC reimbursement practices please ask your ACC case manager.

PAYMENT OF HOSPITAL COSTS

For further information please refer to page 17 of this booklet.

Payment will be made by: ☐ credit card ☐ internet banking ☐ EFTPOS ☐ cash ☐ other*

- If you have no insurance you will be required to pay the full estimated cost of the operation/procedure **on or before admission.**
- If internet banking is done within 3 days prior to your admission, you may need to provide proof of the transaction prior to admission.
- We strongly recommend you contact our bookings team 09 892 2902 for an estimate of the hospital costs prior to admission.
- If you have prior approval with a private health insurer, you will need to pay any expected shortfall on or before 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 Kākāriki Hospital may notify a credit reporting agency and/or instruct a debt collection agency should you default on any payment due by you to Kākāriki Hospital.
- You understand that any collection and/or legal costs incurred in recovering any debt will be charged to you.

PERSONAL PROPERTY

We request you leave all valuables at home. Should you bring such items in with you, you understand and agree that Kākāriki Hospital is not and will not be responsible for loss of or damage to any personal property (including jewellery, dentures, watches, rings, glasses or electronic devices such as laptops or tablets) which you may bring into the hospital.

PRIVACY

We may share your information with other healthcare professionals and agencies involved in your care and treatment. It is normal practice to give necessary and relevant information about you to: your GP, the health care professional who referred you, your community nurse, or other healthcare professionals involved in your ongoing care.

We may also provide your information to the Ministry of Health and other government agencies that require us to provide information for administrative, legal, contractual, statistical, research or public health purposes.

We treat your personal and health information as confidential and have processes to keep your information protected.

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

Signature: _____

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

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You can email this form to reception@kakarikihospital.co.nz