

AFFIX PATIENT LABEL
(Office Use Only)

Account Settlement

For ease of settling your account, you may wish to pay by direct credit into our bank account:
Manuka Street Hospital - ASB 12 – 3193 – 0025426 – 00

When paying by direct credit, please ensure your Invoice Number is the Reference, and your Surname is the Code.

Pre-payment / Paying Personally

Your surgeon will advise whether this procedure requires a prepayment; if it does, please ensure the pre-payment is made within three days of your surgery, or your surgery may be delayed. All procedures being paid privately require a pre-payment. Our direct credit details are above should you wish to make payment via internet banking.

When making a pre-payment by direct credit, please ensure your NHI number (from your surgeon) is the Reference and your Surname is the Code.

Agreement

I agree to settle my Manuka Street Hospital account in full within 30 days of surgery when personally paying my account or where I do not have 'prior approval' from my insurer. I understand I am responsible for any outstanding balance if my procedure is not fully covered by insurance, ACC or other contract. I give permission for Manuka Street Hospital to obtain any information relating to the approval / claim for this admission from the relevant funder(s), and I authorise that person or organisation to disclose such information to Manuka Street Hospital. I accept that, in the event my Manuka Street Hospital account is not paid in full by due date, Manuka Street Hospital reserves the right to add all costs of collection to this account. I accept that, in the event my account is not paid in full by due date, Manuka Street Hospital reserves the right to add interest to the outstanding balance, at the current rate of 19.95%. I understand the admitting Surgeon, Anaesthetist and other doctors or health professionals using Manuka Street Hospital facilities are independent and not employees of Manuka Street Hospital, with respect to both my treatment, care and account payment. I accept that this agreement is covered by New Zealand law.

Name: _____

Date: _____

Signature: _____

If not the patient, state relationship to patient: _____