Manuka Street Hospital

Hospital Administration only

(Patient label)

Patient Admission Form

*Please complete all sections and both sides of the form, and return (deliver, scan, or email) at least **3 weeks prior to your admission.** 36 Manuka Street, Nelson 7010 email: administration@manukastreet.org.nz*

Patient Details

Full Legal Name: _____

Preferred name: _____ Title: i.e. Mr, Mrs _____

Date of birth: _____ Age: _____ **NHI (If *known)*** _____

Gender: _____ **Pronouns** *(Optional)*_____

Residential address: _____

Postal address *(If different from above)*: _____

Email address: _____

Telephone: (*Home)* _____ *(Business)* _____ *(Mobile)* _____

Admission Date: _____ **Surgeon:** _____

Operation: _____

Medical Centre / General Practitioner: _____

Which ethnic group do you belong to? Tick the box or boxes which apply to you.

☐ New Zealand European ☐ Māori ☐ Samoan ☐ Cook Island Māori ☐ Tongan ☐ Asian ☐ Indian

☐ Other (such as Dutch, Japanese, British) Please state: _____

New Zealand resident: ☐ Yes ☐ No If *no, complete the 'Acknowledgement Form: Non-NZ resident'*

Next of Kin / Contact Person

Name: _____ **Relationship to patient:** _____

Address: _____

Telephone: *(Home):* _____ *(Business):* _____ *(Mobile):* _____

Discharge arrangement / Aftercare Consent

Following the procedure, you are not able to drive a vehicle, operate any machinery, take public transport or a taxi.

YOU MUST HAVE SOMEONE TO COLLECT YOU AFTER YOUR PROCEDURE. YOU WILL NEED TO HAVE SOMEONE TO STAY OVERNIGHT WITH YOU, FOR YOUR SAFTEY. Please provide details.

Name: _____ **Relationship to patient:** _____

Address: _____

Telephone: *(Home):* _____ *(Business):* _____ *(Mobile):* _____

Patient confirmation of understanding:

Patient Signature: _____ Date: _____

Please confirm your understanding of the discharge agreement / Aftercare Consent.

Important: Please send this completed form to Manuka Street Hospital 3 weeks prior to your procedure.

Payment Details

How will your procedure be paid for? Tick and complete

☐ **Health insurance** ☐ **ACC** ☐ **Health NZ (Public System)** ☐ **Paid personally** ☐ **Other** _____

Details of health insurance: **Southern Cross Affiliated Provider contract** □

Name of Insurer: _____ Insurance Membership No: _____

Have you obtained "prior approval" for payment? ☐ Yes ☐ No Approval Number: _____

Please provide your prior approval letter in advance

Methods of payment.

I will pay my account by: ☐ EFTPOS ☐ Credit Card ☐ Debit Card ☐ Internet Banking

Internet banking details

Payee: Manuka Street Hospital Bank a/c: 12-3193-0025426-00

Reference: NHI Particulars: Patient Name Code: Date of surgery e.g., 27 Sep 2023

Would you like to receive your invoice via email? ☐ YES ☐ NO

We will send the invoice to the email address you have provided above.

Account Settlement

Payment prior to surgery

You will need to have paid for your surgery 3 days before admission. The amount is based on the estimated cost of the procedure, payable by you not otherwise covered by your insurance, ACC, or Health NZ (Public Health System).
The deposit will be refunded to you if the procedure is cancelled.
Depending on your health insurance policy or plan you may be required to pay an excess (co-payment). This is not covered by insurance, ACC, or Health NZ. (Public Health System).

Please provide your prior approval letter in advance

Agreement

I agree to settle my hospital account in full no more than 30 days after my 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 hospital account is not met, Manuka Street Hospital reserves the right to add all costs of collection to this account.
I give permission to Manuka Street Hospital, or any health professional (such as my medical specialist) involved in my care in relation to this admission to hospital, to access health information about me that is relevant to my treatment (including pre-admission and after discharge), which may be held by Manuka Street Hospital, other health professionals or other health organisations. I understand that other clinical team members such as student nurses and qualified medical trainees may have supervised involvement with my care and that I have the right to decline their presence or contribution to my care delivery.
I understand the admitting Surgeon, Anaesthetist and other Doctors or health professionals using Manuka Street Hospital's 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. The details above have been completed by

Name: _____ **Date:** _____

Signature: _____[☐ Electronic Signature]

If not the patient, state relationship to patient: _____

Important: Please send this completed form to Manuka Street Hospital. Return, deliver, scan, or email at least 3 weeks prior to your admission or ASAP to: Manuka Street Hospital, 36 Manuka Street, Nelson 7010. (Posting, allow 1-2 extra weeks for delivery) or email to: administration@manukastreet.org.nz

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