



## Patient Admission Form

Please complete all sections of this Form at least 3 weeks prior to your admission.

You can: hand deliver, post (Manuka Street Hospital, 36 Manuka Street, Nelson 7010) or complete these on-line by saving a copy to your computer first, complete and then email back. Alternatively, you can print out the PDF version to complete manually and email it back to [administration@manukastreet.org.nz](mailto: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 SAFETY. 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.**

## 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](mailto:administration@manukastreet.org.nz)

**Hospital Administration only**

*(Patient label)*