

MACKAY SPECIALIST DAY HOSPITAL	
85 Willetts Road North Mackay QLD 4740	
Phone: [07] 4977 5100	
Fax: [07] 4977 5199	

PLEASE COMPLETE FORMS IN BLACK PEN AND RETURN TO US AS SOON AS POSSIBLE. IF YOUR ADMISSION IS WITHIN 48 HRS, PLEASE CALL RECEPTION ON THE ABOVE NUMBER TO PROVIDE THE NECESSARY DETAILS.

Proposed Admission Date [if known]: / /	Treating Doctor:
Proposed Surgery / Procedure	
Surname:	[Mr, Mrs, Miss, Ms, Master, Dr]
Given Names [In Full]:	Male <input type="checkbox"/> Female <input type="checkbox"/>
Home Address:	
	Postcode:
Postal Address: [write as above if same]	
	Postcode:

YOU WILL NEED TO CONTACT US ON THE LAST WORKING DAY PRIOR TO YOUR SURGERY.

Medicare No. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Position on Card:	Valid until: / /
Pension Type:	Pension Number:	
Phone (Home):	(Business):	(Mobile):
Date of Birth: / /	Age:	Religion:
Country of Birth: _____	Are you of: <input type="checkbox"/> Australian Aboriginal Origin <input type="checkbox"/> or Torres Strait Islander Origin <input type="checkbox"/> or South Sea Islander Origin <input type="checkbox"/> or None of the above	
Main Language Spoken: _____		
If required will an interpreter accompany you? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Occupation:		
Marital Status:	<input type="checkbox"/> 1. Never Married <input type="checkbox"/> 2. Married / Defacto	<input type="checkbox"/> 3. Widowed <input type="checkbox"/> 4. Divorced
		<input type="checkbox"/> 5. Separated
Next of Kin:	Relationship:	
Address:		
	Postcode:	
Contact Phone No.		
If someone other than your Next of Kin is collecting you after surgery please provide their name and contact details:		
Name:	Phone:	
Have you used this facility previously? <input type="checkbox"/> Yes <input type="checkbox"/> No Please advise if Surname changed:		
Have you been a hospital inpatient in the last 28 days? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, please give details: _____		
Do you have a Health Care Directive <input type="checkbox"/> Yes <input type="checkbox"/> No		
General Practitioner (GP) Name:		

PLEASE COMPLETE THE REVERSE SIDE OF THIS FORM.

HEALTH FUND DETAILS

PLEASE COMPLETE THE FOLLOWING

Fund Name:

Membership No.

Type of Cover:

Annual Excess (if Applicable)

Is this procedure covered by:

YES

NO

Workers Compensation

Claim Number: _____

Veterans Affairs

Entitlement Number: _____

Third Party

Employer: _____

Non Insured

PAYMENT OF ACCOUNTS

ACCOUNTS ARE PAYABLE IN FULL ON THE DAY OF SURGERY. PAYMENTS CAN BE MADE BY CHEQUE, CASH, EFTPOS, OR CREDIT CARD.

To assist you in finding out any costs for your procedure, please complete the following:

Completed

Not applicable

1. If you have health insurance, ring your fund to check whether you are covered for this procedure at Mackay Specialist Day Hospital and if an excess is applicable.
2. If you do not have health insurance, please ring Mackay Specialist Day Hospital with your item numbers to receive a verbal / written quote for your stay.
3. Request written information from your surgeon about any "out of pocket costs" which may apply to the surgical fee.
4. Contact the Mackay Anaesthetic Group on 4942 9544 for information on any "out of pocket costs" which may apply to the anaesthetic fee.
5. If pathology is required, please note that a "Gap Payment" may apply.

PRIVACY PRINCIPLES

1. We acknowledge our obligations to you under the Privacy Act 1988.
2. Our Personal information Management Policy is available at Reception and we are happy to answer any questions you may have concerning the policy.

DECLARATION

I certify that the information contained on this form is true and correct to the best of my knowledge.

I accept full responsibility for payment of all treatment administered at Mackay Specialist Day Hospital including any shortfall in reimbursement by my Health Fund and /or Workers Compensation gap following settlement.

I have had financial costs of my procedure clearly explained to me and understand that:

- Quotes supplied prior to admission are **estimations only**.
- Any excess payable under my Private Health Insurance Fund will be paid on admission.
- I may be required to pay for medical items or pharmacy not covered by my Health Fund however this will be explained to me prior to my procedure.
- I will be liable for any debt collection and/or solicitors' fees incurred if I fail to pay for any additional expenses incurred that is not covered by my health fund

I have been given a copy of my rights and responsibilities and have been given the opportunity to ask questions.

Signature: _____ Date: / /

Relationship to Patient: _____

PLEASE READ YOUR BROCHURE TO ASSIST IN PREPARING FOR YOUR SURGERY AND YOUR DISCHARGE ARRANGEMENTS