Hamilton Health Sciences

Preferred Accommodation Authorization Request - Pre-Admission Form

Hamilton Health Sciences - Patient Accounts
T: 905-521-2100 ext. 77000
E: askfinance@hhsc.ca

Patient's Name _____

Date of Birth: (yyyy/mm/dd) _____

Health Card Number _____

Patient Account Number (if applicable) _____

INSURANCE INFORMATION	1. Primary Holder Insurance	2. Secondary Holder Insurance
Policy Holder Name		
Policy Holder Date of Birth		
Relationship to Subscriber		
Employer Name (former if retired)		
Insurance Company		
Policy / Group		
Cert / Identification Numbers		

PREFERRED ACCOMMODATION DAILY CHARGES

Initials _____

It is the patient's responsibility to know their insurance coverage for room accommodation. My initials indicate I accept financial responsibility for preferred accommodation charges indicated below for the period of my hospitalization and I will be billed if my insurance company does not pay.

PRIMARY CHOICE - INITIAL IN BOX	SECONDARY CHOICE - INITIAL IN BOX
_____ Private (1 bed) - $ 310.00 per day	_____ Private (1 bed) - $ 310.00 per day
_____ Semi-Private (2 beds) - $ 275.00 per day	_____ Semi-Private (2 beds) - $ 275.00 per day
_____ Standard Ward (3 or more beds) – No Charge	_____ Standard Ward (3 or more beds) – No Charge

The room accommodation determines the number of beds and does not include washroom arrangements.

Patient / Guarantor Authorization of Charges

I understand and agree that I am responsible for all preferred accommodation charges resulting from the Hospital Visit. Should the patient receive these services during this visit, I agree to pay all fees.

Initials _____

Authorization for Release of Information

I authorize Hamilton Health Sciences (HHS) to disclose my personal health information (PHI) to third parties as appropriate and/or necessary for the purposes of billing, reimbursement and/or insurance claims including, but not limited to, reports, statements, analysis, diagnosis, and/or other portions of my patient record. I confirm that this authorization will remain valid until such time as any outstanding billing claims are satisfied.

Initials _____

Assignment of Rights

I hereby assign to HHS, all of the benefits associated with hospitalization provided by my insurance, to the extent required to satisfy my indebtedness, or that of my dependent, to HHS and specifically authorize my insurance company/ies to assign all payments to which I am entitled directly to HHS with respect to any and all charges associated with my visit/admission/period of hospitalization.

Initials _____

Patient or Guarantor accepting financial responsibility MUST complete this section.

Printed Name _____ Signature _____

_____ Address _____ City _____ Province _____ Country _____ Postal Code

Phone Number _____ E-Mail Address _____ Date (yyyy/mm/dd) _____