ADMISSION/REGISTRATION
ACCOMMODATION REQUEST AND AGREEMENT FOR PAYMENT FORM

Patient's Last Name (as appears on Health Card)		First Name		Middle Initial	Maiden Name
Street or Rural Number		Town/City		Province	Postal Code
Home Phone No.	Business Phone No.	Date of Birth Year Month Day	Age	Sex ☐ M ☐ F	Language Spoken if not English:
Name of Next of Kin		Relationship	Address & Telephone (if different than above)		
Previous Admission ☐ Yes ☐ No		Name: (if different from above)			
Admission Date	Surgeon/Attending MD	Family Physician (full name & address)			
Allergies: ☐ Drugs ☐ Food ☐ Environment		Diabetes: ☐ Yes ☐ No			

ACCOMMODATION REQUEST AND AGREEMENT OF RESPONSIBILITY FOR PAYMENT

Other Insurance Coverage – Policy/Group#	Health Card#/Version Code	Employer of Insurance Holder (if paid through employer)
Claim#/SIN#	Employer At Time of WSIB Claim	WSIB Claim ☐ Yes ☐ No If WSIB Provide Claim#:

The Health System will make every effort to provide the accommodation requested

Accommodation Requested:	Canadian/Ontario Resident: With valid Health Card	*Uninsured Resident 2012/2013	Non-Residents
☐ Standard Ward (4 persons per room)	No additional room charge	**$1106.00**	$2000.00
☐ Semi Private (2 persons per room)	$240.00 + OHIP	$1106.00 + $240.00	$2000.00 + $240.00
☐ Private (1 person per room)	$280.00 + OHIP	$1106.00 + $280.00	$2000.00 + $280.00
Deposit required:		$1106.00	$2000.00

* May change if Ministry of Health Long Term Care rates are changed

Rouge Valley Health System may act on my behalf and can submit a claim for and receive payment for services covered by my Insurance carrier(s).
Rouge Valley Health System may contact my employer or Insurance carrier to investigate or confirm eligibility for Insurance coverage.

I allow for the release of my Health Records and information to validate Insurance payment and claim.

I/we have read the above stated and understand the charges incurred are my/our responsibilities. Any charges not paid by the Provincial Health Card or Insurance Company will be billed directly to the patient and/or guarantor. I hereby certify that I willingly assume full responsibility as the patient and/or myself (signing as a guarantor) for account payments not paid in full.

Name of Guarantor/Relationship to patient (PRINT) _____

Signature of Patient/Guarantor _____

Date: _____

Witnessed by Hospital Personnel Signature: _____

HOSPITAL STAFF: Please send this completed form to Finance Department upon admission of patient