

**WRHN**Waterloo Regional
Health Network**Preferred Accommodation Form**

Patient Label

Admit Date: _____

| @ Queen's Blvd | @ Midtown Site | @ Chicopee Site |
|--------------------------------|---------------------------------|----------------------------------|
| 911 Queen's Blvd | 835 King St. W | 3570 King St. E |
| 519-749-6660 | 519-749-4300 ext. 2352 or 2604 | 519-749-4300 ext.7082 or 2604 |
| patientaccounts.queens@wrhn.ca | patientaccounts.midtown@wrhn.ca | patientaccounts.chicopee@wrhn.ca |

PATIENT RESPONSIBILITIES / I understand:

- It is the patient's responsibility to review his/her own private insurance coverage prior to requesting a preferred accommodation request.
- The hospital will attempt to place you based on your room preference, but the request cannot be guaranteed due to limited space available.
- You will be charged based on the type of room you request, for the time that you are accommodated in that type of room or better (Request Private, assigned Semi = billed Semi | request Semi, assigned Ward = No charge| request Semi, assigned Private = billed Semi).
- You may be moved during your stay if another patient's medical need requires a semi or private bed.
- If a change to room request is required, it must be confirmed in writing by completing a new preferred accommodation form. If you have any questions, or require assistance completing form, please contact the Patient Accounts at the sites listed above.

Patient email address: _____

By providing your email above, you consent to its use for the provision of your medical bill upon discharge and accept the risks with using this method of communication. You have the right to withdraw consent at any time by contacting Patient Accounts at the sites listed above.

PATIENT'S PERSONAL INFORMATION

| | | | | |
|--|-------------------------|------------------------------|--|--------------------|
| Last name | First name(s) | Chosen name | Date of Birth <small>year / month / day</small> | Age |
| Address | | City | Postal Code | |
| Primary phone # | | Secondary Phone # | | Preferred Language |
| Family doctor | | Surgeon/Obstetrician/Midwife | | Allergies |
| Emergency Contact | Relationship to Patient | Primary phone # | Secondary Phone # | |
| Address <input type="checkbox"/> Same as patient, or | | | | |

| During admission what is your Preferred Accommodation -Please check ONE box: | RATES | INITIALS |
|---|------------|----------|
| <input type="checkbox"/> WARD/ covered by Valid OHIP – 3+ beds | NO CHARGE | |
| <input type="checkbox"/> SEMI-PRIVATE – 2 Bed | \$300/DAY | |
| <input type="checkbox"/> PRIVATE – 1 Bed | \$350/ DAY | |
| Do you have Supplementary Insurance <input type="checkbox"/> No <input type="checkbox"/> Yes (Please provide insurance details on 2 nd page) | | |
| Additional Comments: | | |

PATIENT AGREEMENT WITH WATERLOO REGIONAL HEALTH NETWORK

1. I agree to assume responsibility for any charges not covered by valid Provincial Healthcare Insurance (OHIP).
2. I agree to assign all benefits payable from my insurance company(s) to **Waterloo Regional Health Network**.
3. I hereby authorize **Waterloo Regional Health Network**, to release information requested to my insurance company(s).
4. I will be invoiced for any unpaid insurance balance for upgraded accommodation requests.
5. I understand that in the event Waterloo Regional Health Network is unable to reach me following discharge due to invalid contact information (Invalid address or phone number) that Waterloo Regional Health Network reserves the right to access this information via agencies.

Signature of Patient or next of Kin/Guardian_____
Date_____
Relationship to Patient_____
Interviewed by Staff Signature



Admit Date: _____

| | | |
|---|------------------------------|-------------------------|
| Supplementary Insurance #1 Insurance Policy in name of <input type="checkbox"/> Patient <input type="checkbox"/> Other | | |
| Name | | Relationship to patient |
| Insurance company | Policy, Group, or Contract # | Certificate or I.D. # |
| Insurance coverage provided by employer <input type="checkbox"/> No <input type="checkbox"/> Yes – Please complete information below: | | |
| Employer's name | Employer's address | |
| Supplementary Insurance #2 Insurance Policy in name of <input type="checkbox"/> Patient <input type="checkbox"/> Other | | |
| Name | | Relationship to patient |
| Insurance company | Policy, Group, or Contract # | Certificate or I.D. # |
| Insurance coverage provided by employer <input type="checkbox"/> No <input type="checkbox"/> Yes – Please complete information below: | | |
| Employer's name | Employer's address | |

| | | |
|--|--------------------|---|
| WSIB Information Is this visit due to a work related injury? <input type="checkbox"/> No <input type="checkbox"/> Yes- Please provide details below | | |
| WSIB Claim Number | | Date of Injury <small>year / month / day</small> |
| Employer's name | Employer's address | |

If OHIP or supplementary insurance does not cover all charges, you can provide your credit card information below or choose to receive the bill in the mail.

| | | |
|---|------------------------------------|-------------------------------------|
| Credit Card Information I authorize Waterloo Regional Health Network to process charges based on the information completed below: | | |
| <input type="checkbox"/> VISA <input type="checkbox"/> MASTERCARD | Name of card holder (Please Print) | |
| | Card Number | Expiry Date <small>MM/YY</small> |
| | Signature _____ | |