Pre-Admission Accommodation Request Form

This form is to be provided to Quinte Health - Patient Registration (Quinte 3)

It is strongly recommended that you check with your insurance company to ensure you are covered. If your coverage changes after you have submitted this form, please submit a new one or call ext 2399 during your admission to make any changes.

Last Name, First name (as per Health Card)		**Phone #**	**Provincial Health Card #**	
Mailing address (inluding unit#/PO Box)		**City**	**Province**	**Postal code**
Birthdate DD/MM/YYYY	**Religion**	**Marital Status S/CL/M/D/SEP/W**	**Former Last Name**	
Family Physician	**Attending Physician (OBGYN)**		**Due Date DD/MM/YYYY**	
Next of Kin	**Relationship**	**Address**		**Phone #**
Alternate Contact	**Relationship**	**Address**		**Phone #**

Preferred Accomodation Request (Select 1st & 2nd choice)			I understand that Quinte Health is NOT responsible for my personal effects that are lost, stolen or damaged while in hospital.
WARD _____	**SEMI PRIVATE** _____ **$220.00 per day**	**PRIVATE** _____ **$260.00 per day**	

The undersigned patient/guarantor are financially responsible for all hospitalization charges not covered by the named insurance company or any other agency. I understand that I am responsible for paying all outstanding charges and I agree to pay the balance to Quinte Health. I understand that I am responsible for contacting my insurance provider regarding my coverage and that Quinte Health is not responsible for knowing what my insurance will pay. The hospital reserves the right to add applicable charges without further notice and the right to bill insurance companies in accordance with hospital policy. I also understand that all rates are subject to change without notice and I accept responsibility to pay those rates. My signature below indicates that I have read all the information on this agreement form and understand my responsibilities and that of Quinte Health.

Primary Insurance Company (Name & Address)

Name of Policy Holder	**Employer**	**Group/Policy #**	**ID/Certificate #**

Secondary Insurance Company (Name & Address)

Name of Policy Holder	**Employer**	**Group/Policy #**	**ID/Certificate #**

I assign Quinte Health all hospital benefits payable from this claim or so much thereof as may serve to satisfy my indebtedness or that of my dependent. I authorize Quinte Health to release my information required to settle this claim to the above named insurer.

Date _____ **Signature**_____

Date _____ **Quinte Health Witness**_____

Keep a copy for your own records

QHC#168(RevAPR2023)