South Perth Hospital Inc.

ADMISSION INFORMATION

TO CONFIRM YOUR BOOKING, PLEASE COMPLETE THE ATTACHED FORMS AND FORWARD THEM TO SOUTH PERTH HOSPITAL AS SOON AS POSSIBLE.

POST TO	FAX TO	SCAN and EMAIL TO
PO Box 726 **COMO** WA 6952	"Attention Admissions" 08-9474 2541	reception@sph.org.au

Thank you for choosing South Perth Hospital!
Please read and complete the enclosed forms carefully. If you have any questions or concerns, please contact your doctor, visit our website (www.sph.org.au) or contact us directly, **08-9367 0222**.

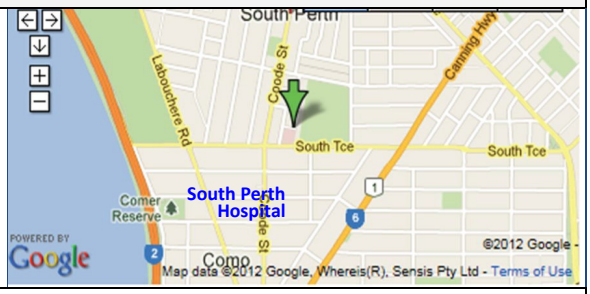
PLEASE RETAIN THIS PAGE FOR YOUR INFORMATION

Parking and Access

South Perth Hospital is located at 76 South Terrace, South Perth, on the corner of Fortune Street (see map).

A large, free car park at the rear of the hospital (off Burch Street) is available for patients and visitors.

For patients and visitors to South Perth Hospital with limited mobility, a disabled parking bay is available at the front door of the hospital to ensure ease of access to the main entrance



Admission Times

Your surgeon's rooms will advise you as to the time of your admission to South Perth Hospital. Please be aware that this may **NOT** match your surgery time.

Visiting Hours

For patients staying overnight, these are between 8.00am and 8.00pm. There are no visiting facilities in the Day Surgery Unit.

No Smoking Policy

South Perth Hospital is a smoke-free environment. Smoking is not permitted in the Hospital or within 5 metres of Hospital grounds. If you feel that you will require nicotine replacement therapy, please discuss this with your doctor prior to your admission.

Boarder Facilities/Local Accommodation

If your child is expected to stay overnight, it is preferable that one parent stay with them. Please make arrangements for the care of other siblings as they cannot be accommodated within the hospital. We recommend that you contact your private health insurance fund to verify if your level of cover includes a provision for a boarder fee. If you require further information, you can contact the Hospital for additional advice.

If you or any of your family require accommodation before or after your procedure, for a variety of options you can visit www.accommodationperth.com.au.

Interpreter/Hearing Impaired Services

Should these services be required, please contact the Hospital prior to admission.

Patient Checklist, have you :

- ☐ **Arranged transport to and from the hospital on the day of admission (you should not drive within 24 hours of anaesthetic)**
- ☐ **A responsible person to collect you on the day of discharge**
- ☐ **A responsible person to stay with you overnight if you are having Day Surgery**
- ☐ **Forwarded the completed Consent for Treatment form (signed by you and your doctor)**
- ☐ **Forwarded the completed Patient Health Questionnaire**
- ☐ **Forwarded the completed Personal Details form**
- ☐ **Forwarded the completed Pharmacy Account form (blue)**

Version 12: August 2016

PLEASE RETAIN THIS PAGE FOR YOUR INFORMATION

Please read the following information carefully. If you are unsure or have any questions please contact:

- **The Hospital**
- **Your doctor**
- **Your health insurance fund**

ACCOUNT INFORMATION

It is **strongly recommended** that you contact your private health insurance fund prior to admission to verify your level of cover and what any potential "gap" fees may be. You will be required to pay any excess or co-payment on arrival to the Hospital. This must be received before your admission can be completed. You may be required to **pay the full amount** of the Hospital account **if** your health insurance fund **deems you to be ineligible to claim** for the cost of your admission. Please refer to the information at the back of this booklet for further information regarding Informed Financial Consent.

If you are uninsured or it is a **"self-funded"** procedure, you will be required to pay the estimated costs of your hospital and theatre fees at the time of your admission. Please contact **Patient Billing (08-9367 0222)** to obtain an estimate. As this will be an **estimate only**, in the event of unforeseen complications or variations from the proposed treatment, the cost may vary.

The Hospital has EFTPOS facilities and accepts most major credit cards (except Diner's & American Express). We **do not** accept personal cheques.

MOTOR VEHICLE & WORKER'S COMPENSATION

Approval must be obtained from the relevant insurer/provider prior to admission.

OTHER COSTS THAT COULD BE INCURRED INCLUDE:

- **Medical** Surgeon and anaesthetist fees. You may also receive separate accounts for assisting surgeons or other consultants.
- **Pharmacy** Medicines required during your admission and discharge medications**.** All discharge medications are supplied by the Community Pharmacy (cnr Coode St and South Terrace, South Perth). An account for these medications will be given/sent to you. The Hospital cannot accept payment for these services.
  During your stay, you may be visited by a Pharmacist, who will be happy to answer any questions you may have about your medications.
  Please complete and return the Pharmacy Account form included in this pack making sure to include the details of any relevant Pharmaceutical or Health Benefits cards.
- **Pathology** e.g. blood tests. These services are not included in your Hospital account and may be partially covered by Medicare. A separate account for these will be forwarded to you after your discharge.
- **Imaging or X-Ray** These services are not included in your Hospital account and may be partially covered by Medicare. A separate account for these will be forwarded to you after your discharge.

AMBULANCE SERVICES

There may be a charge for using ambulance services for patient transfer to and from home, hospital or inter-hospital transfers. Please check with your health insurance fund and/or St John's Ambulance.

WHAT TO BRING TO HOSPITAL

Please follow the fasting instructions provided by your doctor. For further information, please refer to our website, www.sph.org.au.

Please bring the following with you:

- **Health insurance fund membership details, Medicare and pension cards**.
- Letters/referrals/forms from your doctor.
- All X-rays/scans and test results relevant to your admission.
- **All current medication** (in original packaging).
- CPAP machines/crutches/mobility aids (if required pre or post surgery).
- Glasses, contact lens, hearing aids (with cases) if appropriate.
- Loose, comfortable night attire, toiletries and reading material if staying overnight.

Do not bring valuables or large sums of money with you. The Hospital **cannot accept responsibility** for the security of personal items.

ROOM ALLOCATION

Whilst every effort is made to accommodate your requests, room allocation will depend on availability. Where a shared room is requested and a single room allocated, additional fees may apply.

DAY SURGERY PATIENTS

Day surgery patients will be in hospital for between 3 and 6 hours, depending upon the type of procedure. Please be advised that there is **restricted visitor access** to the Day Procedure Unit. Day surgery patients will be allocated to a shared room.

A responsible adult must drive you home and a responsible adult must remain with you overnight.

This may not apply to some patients who have particular types of local anaesthetic procedure. Day surgery patients should not travel on public transport unescorted following any procedure where sedation has been given.

INFECTION PREVENTION INFORMATION

Information on preventing infection can be found on our website (www.sph.org.au) and information packs are located beside each bed.

During your stay, visitors and staff should perform hand hygiene before attending to your care. Keep all dressings clean & dry and inform the nursing staff if they become wet or loose.

It is advised that your friends/family do not visit you if they are unwell.

PRE-OPERATIVE SHOWERING

Before admission, it is recommended that you shower (using soap) prior to arrival. Do not use moisturisers, deodorant , talc or perfume. Please remove nail polish and jewellery and do not apply make-up.

DISCHARGE

Inpatients are discharged between **9.00am and 10.00am**.

Please arrange for a responsible adult to collect you from the ward and transport you home safely. You will receive instructions specific to your procedure from nursing staff before you are discharged. Please follow these instructions. You should discuss any questions or concerns you may have with the nursing staff before your discharge.

SOUTH PERTH HOSPITAL

PATIENT PRIVACY INFORMATION

SURNAME	UMRN
GIVEN NAMES	
D.O.B	SEX
ADDRESS	

Hospital Use Only
Patient I.D. label to be used when available

MUST BE READ AND SIGNED BY PATIENT OR GUARDIAN

Privacy Amendment (Enhancing Privacy Protection) Act, 2012

South Perth Hospital respects and upholds your rights to privacy and protection of personal/health information as outlined by the Australian Privacy Principles contained in the Privacy Amendment (Enhancing Privacy Protection) Act, 2012. Your rights and responsibilities as a patient as outlined in the Australian Charter of Healthcare Rights are also supported. Details of these can be found on our website (www.sph.org.au).

Collection of Personal Information

Information including name, date of birth, gender, health fund/insurance details, medical history and financial consent will be collected by SPH. This is primarily used to ensure that you receive optimal care. However it can also be used for other purposes. Normally we would collect this information directly from you, however in an emergency situation we may need to obtain this from relatives or other sources **if** you are unable to provide consent.

Use of Personal Information

Health information is only used by South Perth Hospital to provide treatment and care, to recover costs from health insurance funds or other insurance agencies, for quality assurance/clinical audit or evaluation activities, for management, service monitoring, training and education, complaint management and accreditation activities.

Disclosure of Personal Information

The personal information collected by SPH about you may only be shared amongst healthcare professionals involved in your care and ongoing treatment both within and outside of SPH. These may include doctors, nurses, allied health professionals and other health service providers. South Perth Hospital is **required by law** to provide certain State and Federal agencies (including the Health Department of Western Australia) with identified data for each episode of care and when a diagnosis of a notifiable disease is made. South Perth Hospital is also **legally required** to provide the Health Funds with information about their clients who attend the Hospital.

We also provide de-identified data to the Private Hospitals Data Bureau about patient attendances. Information about you may be used to inform your next of kin or other authorised persons identified in your admission form. Information may include the outcome of your treatment or to obtain consent for necessary treatment when you are unable to give such consent.

Accessing your Records

You may obtain access to your own records by completing a "Request to Access Personal Information" form. We endeavour to provide you with a range of suitable choices as to how you may access your records.

Fees will apply for processing your request.

Correcting your Records

You may request an amendment of your personal information if you believe it is incorrect, incomplete or inaccurate by completing a "Request to Amend Personal Information" form.

Fees will apply for processing your request.

Privacy Questions/Complaints

Questions about the way in which South Perth Hospital manages your personal information or any complaints regarding the treatment of your personal information should be made in writing and directed to:

The CEO/Director of Nursing, South Perth Hospital, PO Box 726, COMO WA 6952

I have read/had explained to me and understand South Perth Hospital's Information Management practices (as detailed above) and consent to the collection, use and disclosure of my personal information by South Perth Hospital in accordance with all relevant Privacy legislation including the Privacy Amendment (Enhancing Privacy Protection) Act, 2012.

Patient's signature:

Please print name: **Date:**

If consenting on behalf of another individual (e.g. a child or parent), please print that individual's name below

DO NOT WRITE IN MARGIN

PATIENT PRIVACY INFORMATION

MR 1.1

Version 12: August 2016

SOUTH PERTH HOSPITAL

PATIENT PRE-ADMISSION INFORMATION

SURNAME	UMRN
GIVEN NAMES	
D.O.B	SEX
ADDRESS	

Hospital Use Only
Patient I.D. label to be used when available

IMPORTANT REMINDER
Please complete this form and return it to South Perth Hospital by post (**PO Box 726, COMO WA 6952**), fax **08-9474 2541** or email (reception@sph.org.au) as soon as possible prior to admission.
The original document must be brought in on the day of the admission.

SECTION A: TO BE COMPLETED BY MEDICAL PRACTITIONER

Admitting Doctor: **Admission Date:**

Admission Type: ☐ **LA Day Case** ☐ **Day Case** ☐ **Overnight Patient**

SECTION B: PATIENT DETAILS *(to be completed by the patient or their guardian)*

Patient's Medicare Number:

☐☐☐☐☐☐☐☐☐☐ Position Number: ☐ Expiry Date: _____/_____

☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Master **Surname:**

Given name (s):

Date of Birth: **Age:** **Gender:** M / F

Residential Address

Post Code:

Postal Address *(if different from above)*

Post Code:

Contact details: **Ph:** **Mob:** **Wk:**

Email:

Marital status:
☐ Never married ☐ Married/Defacto ☐ Separated
☐ Divorced ☐ Widow/widower

Employment status:
☐ Employed ☐ Unemployed ☐ Home duties ☐ Student
☐ Retired ☐ Pensioner ☐ Child not at school ☐ Other

Country/State of birth: **Religion/denomination:**

Do you require an interpreter? ☐ No ☐ Yes **Language:**

Are you of Aboriginal/Torres Strait Islander origin? Aboriginal ☐ Torres Strait Islander ☐ Aboriginal & Torres Strait Islander ☐

Have you been a patient in South Perth Hospital before? ☐ Yes ☐ No

Surname on previous admission *(if different to current)*:

Pharmaceutical/Concession Card:

Type: _____ Card Number:_____ Expiry Date: ____/____

Department of Veteran's Affairs/Defence Personnel

DVA File Number: DVA Card Colour: ☐ **Gold** ☐ **White**

Defence Force EPID: Approval Number:

Private Health Insurance

Do you have private health insurance? ☐ **Yes** ☐ **No** *(Note that **UNINSURED** patients **MUST** pay all estimated fees on admission. Contact **Patient Billing, 08-9367 0222** to obtain an estimate).*

Name of Health Fund: Table:

Member Number: Excess/Co-payment:

Please check your level of cover, excess and co-payment information with your health insurance fund prior to admission.

Have you been a private patient in a hospital in the past 7 days? ☐ Yes ☐ No

DO NOT WRITE IN MARGIN

PATIENT PRE-ADMISSION INFORMATION MR 1

Version 12: August 2016

SOUTH PERTH HOSPITAL

PATIENT PRE-ADMISSION INFORMATION

SURNAME	UMRN
GIVEN NAMES	
D.O.B	SEX
ADDRESS	

Hospital Use Only
Patient I.D. label to be used when available

SECTION B: PATIENT DETAILS *(cont)*

Health Insurance Details *(Please bring **ALL** relevant cards to hospital on the day of admission)*

Type of accommodation requested: ☐ **Single room** ☐ **Shared room**

☐ **Boarder to stay** *(for dependants only)* **State relationship to patient:** _____

*Whilst every effort will be made to meet your room preference, room allocation is dependent upon availability. Please note that single room fees are higher than those for shared rooms & it is **strongly recommended** that your check your level of health insurance cover prior to admission. Where a shared room is requested and a private room is allocated, additional payment may apply. Day surgery patients will be allocated a shared room.*

Name of person responsible for account (please print)**:**

Address of person responsible (if different to patient address)

Is your admission to SPH related to an accident or injury? ☐ **Yes** ☐ **No.** If **"Yes"**, briefly describe how the injury occurred below?

Patients Claiming Compensation *(Tick appropriate box below).*

☐ **Worker's Compensation** ☐ **Motor Vehicle Insurance Trust**

***Note:** Should your claim **NOT** be accepted by the insurance company, **you will be responsible** for immediate payment of the account)*

Date of injury	State where injury occurred (e.g. WA, QLD):
Employer's name:	
Employer's address & contact number:	
Claim number:	Insurance company:
Contact name & number	

Next of Kin Contact Information

Name: **Relationship to patient:**

Address *(if different to address given previously)*

Post Code:

Ph: **Mob:** **Wk:**

Name of other contact *(in Australia but not living with you):*

Ph: **Mob:** **Wk:**

General Practitioner/Clinic

Name: Ph:

Address:

Infection Prevention & Control

*Please contact the Hospital if you answer **"YES"** to any of the questions related to Infection Prevention & Control*

Have you been a patient, employee or resident in a healthcare facility **outside of** Western Australia in the past 12 months? ☐ No ☐ Yes

If "Yes", please state where & when: _____

Do you have a history of Creutzfeldt-Jakob (cCJD) disease in your family? ☐ **Yes** ☐ **No**

Have you ever had Human Pituitary hormones (growth or gonadotropin) prior to 1986? ☐ **Yes** ☐ **No**

Discharge Planning

After day surgery, you **must** have a responsible adult to collect you from hospital & have someone at home with you for the first night.

Do you have someone to collect you from hospital? ☐ **Yes** ☐ **No**
Do you have someone to stay with you overnight after your day procedure? ☐ **Yes** ☐ **No**

DO NOT WRITE IN MARGIN

SOUTH PERTH HOSPITAL

PATIENT CONSENT TO PROCEDURE

SURNAME	UMRN
GIVEN NAMES	
D.O.B	SEX
ADDRESS	

Hospital Use Only
Patient I.D. label to be used when available

To Be Completed in Full by the Admitting Doctor

Doctor's Name: **Operation Date:**

Patient Name:

Please indicate admission type: **Day Surgery** ☐ **Inpatient** ☐

Principal Diagnosis

Treatment/Procedure *List the treatment/procedures to be performed, noting correct site/side. Do **NOT** use abbreviations.*

Proposed Item Numbers:

This procedure requires: **General and/or Regional anaesthesia** ☐ **Local anaesthesia** ☐ **Sedation** ☐
(An anaesthetist will explain the risks of general/regional anaesthesia to you)

Additional Information *e.g. an outline of other information particular to this patient/procedure.*

Patient Declaration *Please indicate your relationship to the patient below*

☐ **Self** ☐ **Parent** ☐ **Relative** *(has Enduring Power of Guardianship)* ☐ **Other** *(specify)*_____

- The doctor has explained to me my/my child's/relative's medical condition and prognosis to me. The doctor has also explained the relevant treatment options available to me/my child/my relative and their associated risks, including the risk of not having the procedure.
- The risks of the procedure have been explained to me, including risk specific to me/my child/my relative and the likely outcomes. I have had the opportunity to discuss and clarify any concerns with my doctor.
- I understand that the result/outcome of this treatment/procedure cannot be guaranteed.
- I understand that if complications or immediate life-threatening events happen during my/my child's/my relative's procedure, I/they will be treated accordingly.
- I understand that I have the right to withdraw consent at any time prior to the procedure being undertaken, including after I have signed this form. I understand that I must inform my doctor if this occurs.
- I understand that photographs or video footage may be taken during my/my child's/my relative's procedure which are used as teaching aids for health professionals (you/your child/your relative will not be identified in any photo/video).
- I understand that in the event of any staff member or doctor being injured or exposed to my/my child's blood or body fluids during the procedure that blood will be collected for the testing of communicable diseases, including Hepatitis B & C and HIV.
  I understand that I will be informed that blood for testing has been taken, that the results will be available to me, the staff member/doctor injured/the treating medical officer and the South Perth Hospital Infection Control Nurse (or their deputy) and that the staff and doctor's are bound by the Hospital's Confidentiality policy. In the event of the test results being positive, the Privacy Act is waived and the Department of Health (WA) will be notified.
- I consent for myself/my child to undergo the procedure/treatment as documented on this form.
- **I consent to the administration of blood products if needed.** **No** ☐ *(Tick box if you would refuse a transfusion)*

Patient/Guardian Signature

Full name *(please print)*: _____

Signature: _____ **Date:** _____

Medical Officer Confirmation
I confirm that I have explained to the patient/guardian the nature and purpose of the above mentioned operation/procedure/treatment, any alternative treatments available and the benefits and risks of the proposed.

Signature: _____ **Date:** _____

Interpreter Services Used? **Yes** ☐ **No** ☐ ***(Tick appropriate box).*** *I confirm that I have accurately interpreted the contents of this form and related conversations between the patient/person giving consent and the doctor.*

Interpreter Name: _____ **Interpreter Signature:** _____

Other Documents *(tick if applicable & bring with you on admission)* ☐ **Advance Health Directive in place** ☐ **Living Will in place**

DO NOT WRITE IN MARGIN

PATIENT CONSENT TO PROCEDURE MR 2

Version 12: August 2016

SOUTH PERTH HOSPITAL

PATIENT HEALTH QUESTIONNAIRE

SURNAME	UMRN
GIVEN NAMES	
D.O.B	SEX
ADDRESS	

Hospital Use Only
Patient I.D. label to be used when available

PATIENT OR GUARDIAN TO COMPLETE

Reason for admission:

Patient Height (cm): **Patient Weight (kg):**

Please note that South Perth Hospital does not accept patients who weigh more than 140kg

Do you have any Allergies? *(e.g. medications, food, lotions)* ☐ **No** ☐ **Yes** If "Yes", ✓ appropriate box & list below.

	Yes	Nil Known	Name	Reaction Experienced
DRUGS				
LATEX				
SKIN PREPARATIONS				
TAPES				
FOOD				
OTHER				

Previous Medical/Surgical History *Please list any previous operations or serious illnesses/accidents below*

Date	Type of operation, illness or accident

Medications *List **ALL** regular medications (e.g. tablets, pills, injections, puffers, aspirin, vitamins and natural therapies). Please bring all current medications (in original packaging) with you on the day of admission.*

Name of Medicine	Dose/ Strength	Number Times per Day	Name of Medicine	Dose/ Strength	Number Times per Day

DO NOT WRITE IN MARGIN

PATIENT HEALTH QUESTIONNAIRE MR 20

Version 12: August 2015

SOUTH PERTH HOSPITAL

PATIENT HEALTH QUESTIONNAIRE

SURNAME	UMRN
GIVEN NAMES	
D.O.B	SEX
ADDRESS	

Hospital Use Only
Patient I.D. label to be used when available

Yes	No	**Do you or have you ever had any of the following?** *Please* ✓ ***Yes or No*** *to the following questions and give details where applicable/requested)*	**Description**
☐	☐	Have you ever had any problems related to anaesthetics *(i.e. vomiting, difficulty passing urine)?*	
☐	☐	Have you had a recent sore throat, cold or flu *(last 2 weeks)*?	
☐	☐	Have you had any heart problems *(e.g. heart murmur, angina, heart attack, irregular heart beat, valve problems, bypass surgery or other)* ?	
☐	☐	Are you taking anticoagulants? If "Yes", please contact your Dr prior to admission	
☐	☐	Are you taking or have you been taking Aspirin recently?	
☐	☐	Blood Pressure issues High ☐ Low ☐	
☐	☐	Stroke/Blackouts /TIA's /Faints	
☐	☐	Have you had a previous history of deep vein thrombosis (DVT or PE)	
☐	☐	Bleeding tendency or blood disorders	
☐	☐	Breathing problems *(e.g. asthma, sleep apnoea—using CPAP, bronchitis)*	
☐	☐	Diabetes. If "Yes", do you use: insulin ☐ oral medication ☐ diet control ☐	
☐	☐	Special dietary requirements? *Specify:*	
☐	☐	Kidney/ Bladder problems	
☐	☐	Epilepsy/ Fits	
☐	☐	Reflux/ Indigestion/ Ulcers/ Hiatus Hernia	
☐	☐	Arthritis/ Neck or Back problems	
☐	☐	Intellectual impairment	
☐	☐	Depression or other mental illnesses	
☐	☐	Lymphoedema	
☐	☐	Any other medical condition? *Please specify*	
☐	☐	Are you/ could you be pregnant	
☐	☐	Eyesight or hearing difficulties	
☐	☐	Have you had a fall in past 6 months	
☐	☐	Do you use a mobility aid	
☐	☐	Do you use community support services? State which.	
☐	☐	Do you smoke now? (_____/ day for _____years) Have you ever smoked? ☐ Yes ☐ No	
☐	☐	Do you drink alcohol? (average per day/week) _____/day _____week	
☐	☐	Do you use recreational drugs?	

Infection Control Concerns *Have you been diagnosed/treated for any of the following.* **Tick here if not applicable** ☐

Hepatitis A ☐ Hepatitis B ☐ Hepatitis C ☐ HIV ☐ MRSA ☐ VRE ☐

Patient Confirmation: I have answered the above questions to the best of my ability	**Staff Confirmation**
Signature: **Date:**	**Signature:** **Date:**

DO NOT WRITE IN MARGIN

PLEASE RETAIN THIS PAGE FOR YOUR INFORMATION

INFORMED FINANCIAL CONSENT

Please read the following information carefully.
If you are unsure or have any questions please contact:

- **The Hospital**
- **Your health insurance fund**

When you arrive for admission, you will be asked to read and sign an "Financial Consent Information" form. When you indicate your acceptance of these terms, you are acknowledging and agreeing to the following which are conditions of admission. If another person (for example, a spouse or family member) will be responsible for paying the account for your treatment at the hospital, that person should also read the following items before acceptance is indicated, as:

- **Actual expense incurred may differ from the estimate provided.**
  Whilst every effort has been made to provide an accurate estimate of the expenses you may incur, the actual, out of pocket expenses are only known **post-discharge**. Additional costs are some times incurred during your hospital stay. For example;
  - ◊ The hospital relies on information provided by your health fund that may change.
  - ◊ Your treating doctor (s) may vary the proposed treatment, procedure or the proposed length of stay.
  - ◊ Medication costs may vary due to a change of medication prescribed by your treating doctor or a change in the medication price.
  - ◊ You may incur sundry charges during your stay (e.g. visitor meals, boarder fees and phone calls).
  - ◊ Where a prosthesis (an implanted medical device) is required for your treatment, there will be at least one device that will be fully covered by your health fund (if you are insured). However, based on your specific clinical need, your doctor may recommend a device that requires a gap payment by you. Though your doctor should generally advise you if this the case, as with any medical procedure, if unforeseen circumstances should arise during the procedure it may be necessary for your doctor to use a different or more costly prosthetic device. If this happens, there may be additional costs to you.

- **You agree to pay any balance of expenses actually incurred.**
  Your final account will reflect:
  - ◊ The actual procedure performed, treatment and services provided and your length of stay at the hospital.
  - ◊ Disposable and prosthetic items used in your treatment.
  - ◊ Pharmacy costs.
  - ◊ Any balance payable by you.

  As noted in the section entitled "Account Information" actual costs that are known and advised prior to your admission are payable before or on admission and any additional costs are payable on discharge. Please be aware that if **you** chose to cancel your procedure **after** admission, a fee may apply.

  As a condition of admission, once you have indicated your acceptance of these terms, you will be taken to have agreed to pay your final account. If you have any genuine concerns or a bona fide dispute regarding the final account (for example you did not receive a service or an item listed) you agree to raise with the hospital as soon as possible after receiving the account and to use your best efforts to resolve any dispute at the time of discharge or within 7 days of discharge.

- **You must pay the full amount or any outstanding balance if your insurer (or other payer) does not cover the cost of treatment.**
  You are responsible for the payment of the whole account relating to your admission to hospital if your health fund does not cover the treatment, procedure or length of stay. This includes amounts in dispute with your health insurer, e.g. pre-existing queries, waiting periods, exclusion items or external insurance claims.

  This applies in the case of Worker's Compensation claims and disputes with insurers/employers regarding responsibility for payment. The Hospital account remains your responsibility in the instance that an insurer or employer refuses to pay.

- **You are responsible for accounts from other providers.**
  You are responsible for payment of other accounts you may receive, which may include:
  - ◊ The treating doctor (s) or surgeon (s)
  - ◊ The assisting surgeon (s)
  - ◊ The anaesthetist
  - ◊ Pathology services
  - ◊ Radiology services
  - ◊ Pharmacy (discharge medications)