WEST SHORE MEDICAL PRIVATE HOSPITAL

PATIENT NO. _____

ADMISSION

SURNAME: _____ FIRST NAME: _____

AGE: _____ DATE OF BIRTH: _____ SEX: ☐ M ☐ F RELIGION: _____

STATUS: ☐ S. ☐ M. ☐ W. ☐ D. ☐ SEP. ☐ C/LAW OCCUPATION: _____

ADDRESS: _____ PHONE: _____

NEXT OF KIN: _____ RELATIONSHIP: _____

ADDRESS: _____ PHONE: _____

_____

DATE ADMITTED: _____ TIME: _____

ADMITTING PHYSICIAN: _____ PHONE: _____

DISCHARGE DATE: _____ TIME: _____

FAMILY PHYSICIAN: _____ PHONE: _____

HEALTH INSURANCE/COMPANY: _____

YES ☐ NO ☐ PHONE: _____

PAYMENT AGREEMENT

1. The Patient/Relative who signs this agreement shall be liable to pay West Shore Medical for all services provided in the treatment of the patient.
2. That all payments shall be made either by CASH, LINX, MANAGER'S CHEQUE OR VISA/MASTERCARD.
3. a) I agree to pay in full for the cost of the surgical procedure prior to the surgery or
   b) I agree to pay the required deposit and interim payments to ensure the account remains in credit to ensure continuity of service and acknowledge that the Financial Advisor will be in contact with me to advise of interim payments.
4. If in default of payment, I acknowledge that legal proceedings will be initiated by West Shore Medical against me.

PHYSICIAN STATUS

I acknowledge and agree that West Shore Medical is not responsible for the judgment or conduct of any physician who treats or provides a professional service to me, but rather each *physician is an Independent Contractor who is self-employed and is not the agent, servant, or employee of the hospital.* I further understand that other physicians may be called upon to provide cares, either directly (as consultants) or indirectly through professional services (i.e. radiology, Pathology, ECG interpretations, Anesthesiology). These physicians are also independent contractors who are self-employed and are not the agents, servants or employees of the hospital. It is also understood that for emergency or unscheduled services, the hospital may aid my selection of physicians by an established "on-call" roster provided through each department of the hospital. These physicians are also independent contractors who are self-employed and are not the agents, servants, or employees of the hospital. I further agree the hospital is not responsible for the judgment or conduct of any of the physicians identified above.

ROOM REQUEST/OR UPGRADE

ROOM REQUESTED: _____ AVAILABLE: YES ☐ NO ☐

ROOM COST: _____ PACKAGE PRICE: _____

UPGRADED ROOM PRICE: _____

DIFFERENCE: _____

I agree to the above terms and conditions, in particular the payment method. I also fully understand the Physician's status as an Independent Contractor.

_____ _____

PATIENT/REPRESENTATIVE PATIENT/REPRESENTATIVE SIGNATURE

DATE: _____ ADDRESS/TEL #: _____

_____

_____ _____

WEST SHORE REPRESENTATIVE WEST SHORE REPRESENTATIVE SIGNATURE