Patient Label:

Preferred Accommodation Request Form

If you do not have OHIP coverage or valid Provincial or Federal health insurance, please complete the *Hospital Services for Uninsured Persons Payment Form*. Provincial Health Insurance and Workplace Safety and Insurance Board provide basic Ward Coverage (3+ beds per room) to their insured at no cost. **You may have coverage for semi-private and private rooms through private health insurance benefits.**

Process:

- **Please verify your insurance policy coverage so we can bill your insurance company directly for your preferred accommodation.**
- If your insurance company **does not** cover the full amount of your hospital bill, or if you do not have insurance coverage, the **responsibility for payment remains with you.**
- **Your insurance company will only be charged for the days that you stay in a Preferred Accommodation (Private, Semi-Private) room.**
- Hospital beds are assigned based on medical necessity and bed availability. If your preferred room type is not available or suitable at the time of your admission you will be placed in the most clinically appropriate and available room or bed space.
- There may be times where you will need to change rooms due to the clinical requirements of another patient.
- If you decide to change/upgrade your room accommodation during your stay, it may be possible depending on room availability at the time. Please advise a member of your care team of your request.

Patient's Personal Information				
Last Name	First name(s)	Preferred Name	Date of Birth (MMM, DD, YYYY)	Age
Address	City			Postal Code
Primary phone #	Secondary Phone #	Preferred Language		
Patient email address: _____ By providing your email address, you consent to its use for the provision of your 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 (see FAQ for contact information).				
Emergency/Alternate Contact Information				
Emergency/Alternate Contact Name	Relationship to Patient	Primary phone #	Secondary Phone #	
Address: ☐ Same a patient, or:				

Patient Label:

Preferred Accommodation Request: Room Type and Rates Please check one box and initial		
	Cambridge Memorial Hospital, Groves Memorial Hospital, Guelph General Hospital, Waterloo Regional Health Network	**St Joseph's Health Care Guelph (Post-Acute)**
Ward (3 or 4 beds /room)	☐ No charge, OHIP covered *Initials* _____	
Semiprivate (2 beds /room)	☐ $300/day *Initials* _____	☐ $185/day (Rehab/CCC) *Initials* _____
Private (1 bed /room)	☐ $350/day *Initials* _____	☐ $223/day (Rehab/CCC) *Initials* _____

Authorizations: Please initial beside each item to indicate your consent

_____ 1. I certify the information given on this form is true, correct and complete to the best of my knowledge.

_____ 2. I have verified my private insurance policy coverage prior to making my room selection and if I do not have insurance coverage, I agree to pay the room charges I have selected.

_____ 3. I authorize the Hospital to release medical information required for this claim to the insurance companies involved if required and/or requested by the insurance carrier.

_____ 4. I hereby assign to the Hospital all of the hospitalization benefits provided by my hospital insurance to satisfy my indebtedness or that of my dependent.

_____ 5. If I am transferred to another Waterloo Wellington hospital facility, I authorize the Hospital to communicate my insurance information to the receiving facility.

_____ 6. Payment of Account: I agree to make full and immediate payment for charges not covered by any other agency.

_____ 7. I understand that if the Hospital is unable to reach me following discharge due to invalid contact information, the Hospital reserves the right to access this information via other agencies.

Signatures:

_____ _____

Signature of Patient/Signing Authority Date

_____ _____

Relationship to Patient (for Signing Authority) Hospital Staff Name & Signature

Patient Label:

Insurance and Payment Information

Supplementary Insurance #1 Insurance Policy in name of ☐ Patient ☐ Other		
Subscriber's Name	Relationship to patient	
Insurance company	Policy, Group, or Contract #	Certificate or I.D. #
Coverage/additional comments:		
Insurance coverage provided by employer ☐ No ☐ Yes – Please complete information below:		
Employer's name	Employer's address	

Supplementary Insurance #2 (if applicable) Insurance Policy in name of ☐ Patient ☐ Other		
Subscriber's Name	Relationship to patient	
Insurance company	Policy, Group, or Contract #	Certificate or I.D. #
Coverage/additional comments:		
Insurance coverage provided by employer ☐ No ☐ Yes – Please complete information below:		
Employer's name	Employer's address	

WSIB Information Is this visit due to a work-related injury? ☐ No ☐ Yes - Please provide details below:		
WSIB Claim Number		Date of Injury (MMM/DD/YYYY)
Employer's name	Employer's address	