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 year / month / day	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 ☐ Same a patient, or

During admission what is your Preferred Accommodation -Please check ONE box:	RATES	INITIALS
☐ WARD/ covered by Valid OHIP – 3+ beds	NO CHARGE	
☐ SEMI-PRIVATE – 2 Bed	$300/DAY	
☐ PRIVATE – 1 Bed	$350/ DAY	
Do you have Supplementary Insurance ☐ No ☐ Yes (Please provide insurance details on 2nd 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

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

Supplementary Insurance #2 Insurance Policy in name of ☐ Patient ☐ Other		
Name	Relationship to patient	
Insurance company	Policy, Group, or Contract #	Certificate or I.D. #
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 year / month / day
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:

☐ VISA ☐ MASTERCARD	Name of card holder (Please Print)	
	Card Number	Expiry Date MM/YY
	Signature _____	