WOODLANDS HOSPITAL

ADMISSION FORM

FOR OFFICE USE ONLY (All dates in DD/MM/YYYY format)

MR / ☐☐ / ☐☐☐☐☐☐ IP / ☐☐ / ☐☐☐☐☐☐ BED: ☐☐☐ WARD : _____

ADMISSION DATE : ☐☐☐☐☐☐☐☐ TIME : ☐☐☐☐ AM / PM. Under DR. _____

PROCEDURE DATE : ☐☐☐☐☐☐☐☐ TIME : ☐☐☐☐ AM /PM. OT Floor : _____ OT No. _____

Surgeon 1 DR _____ Surgeon 2 DR. _____ Duration : _____ Hrs.

Anaesthetist DR. _____ OT Time : From ☐☐☐☐ AM / PM. To ☐☐☐☐ AM / PM.

Special Instructions : _____

EDD (For Obs. Cases) ☐☐☐☐☐☐☐☐ Diagnosis _____

Estimate: Rs. _____ Advance : Rs. _____ Total Bill : Rs. _____

Total Paid : Rs _____ Total Due : _____ Discharged on : ☐☐☐☐☐☐☐☐

PAYMENT BY : ☐ PATIENT / PARTY ☐ OTHER (Name) _____

INFORMED: ☐ MATRON ☐ HOSPITAL ADMINISTRATOR ☐ HOUSEKEEPING ☐ F & B

TO BE FILLED IN BY THE PATIENT / AUTHORISED PARTY

(PLEASE FILL IN BOLD LETTERS - All dates in DD/MM/YYYY format)

ave you registered as an Inpatient / Outpatient before ? ☐ YES ☐ NO

RST NAME : _____ MIDDLE NAME : _____ LAST NAME : _____

E NAME : _____ AGE : _____ Years Date of Birth : ☐☐☐☐☐☐☐☐ Sex : ☐ MALE
r Maternity Cases)

DDRESS: _____ ☐ FEMALE
ocal)

lice Station : _____ Pin Code : _____ Residence Phone No. : _____

DDRESS : _____
ermanent)

lice Station : _____ Pin Code : _____ Residence Phone No. : _____

cupation : _____ Name & Address of Employer : _____

_____ Office Phone No. : _____

ail ID : _____ Mobile No. : _____ Fax No. : _____

ligion : _____ Nationality : _____ Passport No. (Where applicable) _____

te & Place of Issue : _____ Date of Expiry : _____ Kolkata Phone No. : _____

me of Father / Husband : _____ Occupation : _____

her Next of Kin / 1. Name : _____ Relation : _____ Contact No. : _____
ergency Contacts :

LS PAYABLE BY ☐ SELF* ☐ COMPANY / CORPORATE (Name) _____

(Subject to submission of Letter of Guarantee from Company)

☐ CASHLESS THROUGH TPA (Name) _____ CARD NO. _____

(Subject to Valid Authorisation and Self Payment of Balance / Non-reimbursables)

FERRED BY : ☐ FAMILY DOCTOR ☐ COMPANY DOCTOR ☐ OTHER DR. (Name) _____

OM REQUESTED FOR : ☐ SINGLE ☐ DOUBLE ☐ OTHERS. DIET : ☐ Veg. ☐ Non-veg.

ase note that allocation will depend on availability. Any request for change of room must be submitted in writing to the ward-in-charge or admission office. Transfers be made as per medical priorities - In case of disputes, the decision of the Medical Director will be treated as final.)

CONSENT TO ADMISSION & TREATMENT(Please read carefully)

am authorized to sign the Consent to Treatment form (In case of self payment, the individual paying for the hospitalization must sign). I have been explained about the Hospital's facilities and I have clarified my queries on the same. I hereby agree to admit the above patient to Woodlands Multispeciality Hospital Limited and request Dr. ..... and his team to commence treatment.

I understand & accept all of the following :

1. The completion of this form does not automatically entitle me / my ward to admission.
2. I will pay the applicable advance on admission & settle all hospital bills in full before the discharge of my patient. I understand that I must direct the Billing Dept. personally to release the bill, when I am prepared.
3. I will strictly abide by the rules & regulations of the hospital it is my responsibility to be informed of the policies and protocols of the Hospital and I will ask authorized staff to help me know and follow the rules.
4. I will follow up with the Billing Dept. regularly for my bills and settle them at the earliest opportunity.
5. Tests for Hepatitis B & C are mandatory for admission to this hospital, irrespective of Insurance coverage.
6. I take full responsibility of any valuables that I bring. The hospital accepts no liability for the same.
7. The hospital will not be liable for any incidents caused by me, my visitors, other patients and their visitors and the public at large- including any delay / error in submitting information / consent vital to treatment.
8. The hospital will make every effort to ensure timely services but in case of any process delays due to unavoidable circumstances, I undertake not to hold the hospital responsible for the same.
9. I agree to pay the full deposit / advance amount applicable, at the time of admission.
10. I understand that formalities like issue & return of medicines, completion of transactions, entry-of discharge documents etc. are activities which begin with the doctor ordering a discharge & take time . Therefore routine discharges should be ordered the previous day. The Hospital levies additional room rent charges for late check-outs (Half-day post 12 noon & Full day post 4 pm).
11. I accept full responsibility for all payments made directly to any of the doctors treating the patient. The Hospital will not be liable for such transactions.
12. I/We shall not claim or be entitled to any facility/medical care which are not available in the hospital.
13. I/We shall not make the hospital authority liable of discontinuing/withdrawal of any facility due to the reasons beyond control of the authority.
14. I/We have been explained by my treating doctor about the plan of care, risks arising out of this and also the treating doctor has explained to me regarding alternative methods including use of blood and blood products, as may be required to provide best possible treatment.
15. I have been explained that I might have to go outside the hospital for investigation/procedure advised by my doctor if the facility for such investigation/procedure is not available in this hospital and consent to the same.
16. During treatment the doctor may come to know about any pre existing disease whose treatment may be necessary before or after the treatment of existing disease. In such case doctor will be free to use his discretion.
17. I also give my consent for re-surgery in emergency, if required.
18. Knowing that there is no guarantee about the result of treatment, I give my consent and support to the instruction of the doctors who will follow the best of clinical practice during treatment.
19. I understand & give consent to inform any notifiable disease by the hospital administration to the appropriate authority as per statutes.

DECLARATION

I state that I am having history of

		DURATION			DURATION
(a) Heart disease	YES/NO	.....	(g) Jaundice	YES/NO	.....
(b) Hypertension	YES/NO	.....	(h) Steroid Therapy Past/Present	YES/NO	.....
(c) Diabetes	YES/NO	.....	(I) Alcohol Consumption	YES/NO	.....
(d) Respiratory Problem	YES/NO	.....	(j) Known Allergies	YES/NO	.....
(e) Bleeding Disorders	YES/NO	.....	(k) Complications of Previous Anesthesia(if nay)	YES/NO	.....
(f) Seizure Disorder	YES/NO	.....	(l) HIV positive	YES/NO	.....
			(m) I am having loose/false teeth	YES/NO	.....

Next of Kin Particulars :

Sl. No.	Name in Block Letter	Relation with Patient	Contact No. with Address	Signature & Date

OTHER TERMS AND CONDITIONS

20. OT Advance to be paid at least 3hrs. before the OT timing.
21. The Indent/Credit of cut medicine is not practiced here.
22. The In-house assistant fees will be applicable.
23. In the Paediatric ward, the mother stay charge will also be applicable.
24. Medical Records charges will be levied with every IP.

ADDITIONAL TERMS FOR CASHLESS ADMISSIONS - THROUGH CORPORATES / TPAs / MEMBER COMPANIES

25. All disputes relating to Cashless admissions must be settled between the patient & the insurance provider / corporate directly the Hospital will not be responsible for mediating the same.
26. The Hospital only assists in processing Cashless admissions - it does not guarantee the same. The full responsibility for obtaining an authorization form the TPA and paying for balance / non-reimbursable amounts lies with me (patient / party). I am fully aware of my policy / agreement details.
27. Delays caused by Third parties will incur additional charges for stay and any services provided and I will pay for all such directly to the hospital.
28. The Hospital will not accept responsibility for processing of patient details / documents received beyond 24 hours of admission. ALL Daycare admissions MUST be pre-approved. NO CASHLESS FACILITIES FOR LESS THAN 24 HOUR HOSPITALISATION.
29. No patient of Cashless hospitalization can be released without documented Authorisation from the TPA.
30. An advance will be taken to cover non-reimbursable expenses and the balance, if any will be refunded, at discharge.
31. If Cashless Hospitalisation in denied, the Case will automatically be treated as a Self Payment & the Hospital will request for immediate down payment of all Bills. Under no circumstances will the Hospital further pursue the claim with the TPA.
32. The Hospital will only allow Cashless processing for a single policy alone, for any one admission. Claims for other policies, if any, will have to be done through the process of reimbursement.
33. In case of a denial subsequent to approval of Cashless Hospitalisation by the TPA, at any time, & due to any reason(s), I will settle all bills in full, at discharge & if the denial is after discharge, then within 10 days of intimation of the same, failing which the Hospital will initiate appropriate legal action to recover the same.
34. The process of discharge approval takes time - my Doctor must be informed well in advance to order the discharge at least 24 hours prior to my planned time of release, if any.
35. The Insurance Help Desk will be operational on Sundays & Public holidays between (8-4).

I confirm that the information submitted by me overleaf is correct and understand that I will be required to provide documentary evidence to change or alter any of this information subsequently.
I consent to the hospital releasing any information from the patient's medical records to authorized parties, as & when deemed necessary, in accordance with the hospital policies.

Full Signature of the Patient for

Self consent

Date & Time :

Contact No. :

E-mail :

Full Signature of witness

Name :

Relation :

Address & Contact No. :

Full Signature of Next of Kin / Relative

Date & Time :

Name :

Relation :

Address & Contact No. :

E-mail :

Signature of the EMO/Admitting Officer