WELWITSCHIA HOSPITAL

ADMISSION

Welwitschia Hospital, Rikumbi Kandanga Road, Walvis Bay
Telephone: (+264 64) 218 911 Facsimile: (+264 64) 218 946

COMPLETED FORM TO BE HANDED IN AT WELWITSCHIA HOSPITAL RECEPTION AT LEAST 2 DAYS PRIOR TO ADMISSION. MEDICAL AID MEMBERSHIP CARD AND ID / PASSPORT DOCUMENT MUST BE PRODUCED ON ADMISSION.

PATIENT DETAILS

Surname		Initials		Title	
Full Name		I.D. / Passport			
Date of Birth		Male (X)		Female (X)	
Postal Address					
Residential					
Telephone Details	Cell		Home	( )	
Occupation			Employer		
Work Address					
Work Telephone	( )		E-mail Address		
Name of Close Relative			Relationship		
Telephone Details	Cell		Home/Work	( )	

MAIN MEMBER DETAILS

Name and Surname			
I.D. Number / Passport No.			
Postal Address			
Residential Address			
Occupation		Employer	
Telephone Details	Cell	Home/work	( )
E-mail Address			

INFORMATION REQUIRED FROM MEDICAL AID 3 DAYS BEFORE ADMISSION

Medical Aid / Insurance Name		Option	
Medical Aid Number		Medical Aid Contact Person	
Confirmation Number			
Medical Aid Approved Length of Stay		Date of Confirmation	

TO BE COMPLETED BY DOCTOR

Admitting Doctor		Referring Doctor	
Diagnosis			
Procedure			
Date of Operation / Admission		Time	

I CONFIRM THAT THE ABOVE INFORMATION IS TRUE AND CORRECT.

SIGNATURE _____ **DATE** _____

CONDITIONS OF ADMISSION

1. The signatory of this form hereby states that he/she is the Legally Authorised agent of.....(company) and therefore duly authorised to bind and hold the company to this agreement / or
2. The signatory of this form shall be personally liable to settle the account of the Hospital on presentation thereof, notwithstanding possible membership of a Medical Aid Fund,
3. The signatory authorises the Hospital to submit its account to the Medical Aid Scheme of the patient or signatory, if the Hospital elects to do so.
4. As it is a requirement of Medical Aid Funds, the signatory of this form authorizes the Hospital, through its Pharmaceutical Division, to substitute original medicines, prescribed by qualified Medical Doctors, with the generic equivalent, if available.
5. Any account that is not paid when due, shall bear interest calculated at the rate of 2.5% per month; a part of a month to be regarded as a full month.
6. The legal relations between the debtor/s and the Hospital, arising directly or indirectly from the admission of the patient to the Hospital or in respect of any treatment administered to the patient in the Hospital, shall be determined exclusively in accordance with the Laws of the Republic of Namibia and furthermore any competent Magistrate's Court in the Republic of Namibia shall have jurisdiction in all matters so arising, notwithstanding the amount of the cause of action.
7. Any person who signs this Admission Form, whether as patient, or on behalf of the patient, or as guarantor of the patient undertakes(s), in the event of an account being unsettled for any reason and being referred to attorneys for collection, to be jointly and severally liable for the payment of all costs on an attorney and own client scale, All collection commission and all tracing costs. All outstanding amounts will be recovered in the following order: attorney's fees, collection commission,tracing fees, interest and capital.
8. The signatory undertakes to pay the Hospital's legal costs and collection commission as per approved scales of Agreement.
9. The Hospital is hereby authorized to submit the patient for screening for diseases that are determined by the Hospital and to submit such patient for immunization and treatment of such diseases.
10. The Hospital will not be held responsible for the loss of any personal belongings, which are lost or left behind on the Hospital premises.
11. ***Private patients:*** Deposits must be paid on admission and the balance on discharge.
12. I acknowledge and agree that any medical practitioner or any other medical professional, who is not an employee or agent of the Hospital, who treats the patient is an independent practitioner and the hospital shall not in any way be responsible or reliable for any acts or omission or breach of contract of such medical practitioner or medical professional.
13. The hospital, its employees and agents shall not be liable for, and I hereby indemnify the hospital, its employees and agent from all liability for any loss, injury and/or damage of whatsoever nature suffered by whomsoever, including but not limited to, loss or damage(direct,consequential or indirect), any injury (including a terminal diseases) contracted by the patient, whatever the cause may be, whilst hospitalized, receiving treatment or any other services whilst present at the Hospital, whether arising either directly out of any act or omission, delict or breach of contract by the hospital, its employees or agents.
14. Neither the Hospital, its employees or agents shall be liable for any direct or consequential loss or damage suffered by any person whomsoever and howsoever arising.
15. ***Disclosure of Medical Information:*** The Management of the hospital and any medical practitioner who treats the patient are hereby authorised to disclose to the medical aid/medical benefit scheme, or the Compensation Commissioner or insurer to whom a claims submitted in relations to amounts payable to the hospital full details as to the nature and extent of the illness or condition of and any treatment rendered to the patient.

FULL NAME (PRINT) _____ **DATE** _____

SIGNATURE _____