

**ACCOMMODATION
REQUEST FORM**



ADMISSION DATE: ___ / ___ / ___
MM DD YR

Prices in effect April 1, 2011 to March 31, 2012

Guarantee for Payment

I understand and agree to assume full responsibility for payment of services provided by St. John's Rehab Hospital according to the conditions outlined below.

- I authorize payment of benefits by my insurer to St. John's Rehab Hospital. I understand that I am financially responsible for any unpaid portion and any charges not covered by my insurance plan.
- Charges incurred for services not covered by the Ministry of Health, including telephone charges, assistive devices and/or equipment (i.e. crutches, canes, cushions, splints) are payable prior to my discharge from the hospital.
- If my insurance company declines payment, or does not fully supplement payment for extended health benefits, the balance of payment will be due upon receipt of notification from my insurance company.

Signature of Patient/Guarantor: _____ Date: _____

Acceptance of Services

Room Type	Particulars	Cost Per Day	Authorization/Signature (agrees to accept charges)
Standard Ward	4 beds per room	Covered by OHIP, WSIB, Provincial Health Ins..	
Semi-Private	2 beds per room	\$225.00 /day extra	
Private	1 bed per room	\$250.00 /day extra	
Telephone	Cost=\$2.00 per day	Please choose and circle:	YES NO

Insurance Information

Name of Insurance Provider: _____

Group Number: _____ Subscriber's Number: _____

Subscriber's Name: _____ Relationship to Subscriber: _____

Name of Employer: _____

Please check your Insurance Policy for Rehabilitation Hospital Coverage

Credit Card Information

I authorize St. John's Rehab Hospital to charge my credit card for charges incurred for above patient.

Name of Credit Card Holder: _____

Visa / Master Card# _____ Expiry Date: _____

Amount: _____ Signature: _____ Date: _____

Witness Name: _____ Witness Signature: _____

Hospital Use Only :

TC / PA Signature: _____ **Central Booking Signature:** _____