Sunnybrook
ST. JOHN'S REHAB

ACCOMMODATION REQUEST FORM

ADMISSION DATE: ____/____/____
MM DD YR

Guarantee for Payment

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

- I authorize payment of benefits by my insurer to St. John's Rehab. 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.
- I understand that during my stay I may be relocated to another bed, room, or unit to accommodate the urgent medical needs of a patient. If my requested room is not available, I will be billed according to the accommodations provided.

Signature of Patient/Guarantor:____________________________ Print Name:_______________________ 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 Insurance**	
Semi-Private	**2 beds per room**	**$260.00 /day**	
Private	**1 bed per room**	**$290.00 /day**	
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 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**: ______________________