IntraCare

Terms and Conditions

Personal property

You understand and agree that IntraCare is not and will not be responsible for the loss of, or damage to, any personal property (including jewellery, dentures, watches, rings, glasses) which you may bring.

Payment terms

- The price shall be as indicated on the invoice(s) provided by IntraCare to you in respect of the Services supplied. Unless otherwise stated, all prices include GST.
- For insurance funded procedures, IntraCare requires a copy of the prior approval letter. If we do not receive the prior approval letter at least one business day prior to your admission, you will need to pay for the procedure and claim this back from your insurer.
- IntraCare is affiliated with Southern Cross and AIA, IntraCare can claim the cost of some procedures from these affiliated providers. If you are unsure whether your procedure is covered, please contact our administration team on (09) 630 1961.
- If you are not fully insured and/or have an excess or co-payment, you will need to pay the portion not covered by insurance and/or the excess, at least one business day prior to your admission. If payment is not received within this time frame, your procedure booking date may be rescheduled. Please contact our administration team to arrange payment.
- Any amounts due to IntraCare relating to your procedure either from you, your insurance provider or other party remains your full responsibility, however arising, including overdue payment, nonpayment, outstanding part-payment or if your insurance provider or other party subsequently declines cover or part cover.
- If you have an outstanding balance due to IntraCare, you agree to indemnify IntraCare from and against all costs and disbursements incurred by IntraCare in recovering the debt (including but not limited to internal administration fees, legal costs, IntraCare's collection agency costs and bank dishonour fees).
- The actual cost of the procedure may vary to the estimate. If you are not fully insured and/or have an excess or portion to pay, you may be invoiced for an additional amount if the actual cost of your procedure is higher than the estimate. This is payable upon invoice. If the cost of the procedure is lower than the estimate, you may be eligible for a refund for any overpayment. Refunds are typically paid within 7 business days.

Privacy and financial interests disclosure statement

For the purposes of this Privacy and Financial Interests Disclosure Statement, "IntraCare" is an agency, and means:

1. The Company, Intra Limited, employees including technical staff, nursing staff and administrative staff; and,
2. Medical Specialists credentialed to work with IntraCare.

IntraCare understands the privacy of your personal and health information is important to you. In this Statement we use the term "Personal Information" to include both personal and health information, and we explain how we meet our obligations under the Privacy Act 2020; Health Information Privacy Code 2020 and other relevant legislation when we collect, use and share your Personal Information.

Collection of your Personal Information:

IntraCare usually collects Personal Information directly from you. We also collect information about you from the doctor or agency that referred you to IntraCare. Where necessary to support your diagnosis and treatment and ensure we can provide you with safe and effective services we may also collect Personal Information about you from other healthcare providers involved in your healthcare such as: your General Practitioner, specialists, hospitals, and diagnostic providers (including laboratories and radiology services). This information may be received through referral letters, test results, clinical reports, or shared electronic health record systems. We may also collect Personal Information from ACC or another funder of your care (for insurance funded procedures) your family or whānau with your consent, or other sources if you consent or we are authorised by law.

Purposes for which we use your Personal Information:

We collect and use information about you to ensure we can provide high quality, safe and effective services to you. This may include, but is not limited to: the provision of medical care and advice; making appropriate referrals to other health professionals; monitoring the quality of, and improving, our services; providing relevant training to our staff and health professionals providing services at IntraCare; responding to enquiries, concerns or complaints; and for matters related to the administration of those services including charging, billing, and debt collection. We also securely share limited personal data with Cemplicity for the sole purpose of facilitating a patient feedback survey invitation to you. The data shared with Cemplicity will not be held longer than the purpose of conducting the patient's survey i.e. 21 days. All data stored by Cemplicity is to ISO 27001 standard and in accordance with the Privacy Act 2020.

Access and correction of your Personal Information:

You have a right to seek access to and correction of Personal Information we hold about you in accordance with the Privacy Act 2020 and Health Information Privacy Code 2020. To ensure the security of your information, we will ask you to verify your personal details, before we release any information to you.

Possible financial interest in the facility or part of the facility:

The doctor you see may have a financial interest in part of the facility in which you receive treatment or may be referred to, but at all times has a duty to act in your best interests when making referrals and providing or arranging treatment or care. If you have any questions about this please ask the doctor concerned.

IntraCare is the agency collecting your Personal Information and holding that information. Our office address is 98 Mountain Rd, Epsom, Auckland. If you have any questions relating to how your personal information is collected, used or may be disclosed please contact our Privacy Officer at: admin@intracare.co.nz or (09) 630 1961.

Intended recipients and disclosure of your personal information:

When you receive treatment or procedures at IntraCare, a procedure report is provided to your referring health professional. We may also disclose relevant Personal Information connected to the provision of your medical care and/or the services provided to you by IntraCare, to: your General Practitioner; other health professionals or health service providers involved in your treatment or diagnostic services or where we make referrals on your behalf; or to Health New Zealand and/or ACC where relevant. We provide relevant information to Testsafe, a secure electronic database provided by Health New Zealand. This enables health providers who are involved in providing care to you to access relevant clinical information to improve services to you, especially in the event of a complication or emergency. Only authorised health providers have access to this system. We may also disclose relevant Personal Information about you where it is necessary to submit health insurance claims on your behalf; for quality assurance, audit and accreditation issues; or where the disclosure is otherwise authorised or required by law.

Providing Personal Information and signing this Statement:

You do not have to provide Personal Information to IntraCare, however not providing Personal Information may impact on our ability to provide you with the services you require. By ticking that you consent, and signing this Privacy and Financial Interests Disclosure Statement, you consent that your Personal Information may be collected, used and disclosed as explained above. If you do not consent to the possible disclosure of your information to a third party outside of IntraCare as set out above, please tick the "do not consent" box, and we will request your consent in relation to any specific disclosure that is proposed, unless the disclosure is authorised or required by law.

Signature

I understand my Personal Information will be collected and used for my treatment or procedure.

Please tick one:

☐ **I consent** to my Personal Information being collected, used, and shared as explained in this Statement

OR

☐ **I do not consent** to my Personal Information being collected, used and/or shared as explained in this Statement

I understand that the doctor I see may have a financial interest in part of the facility but is required at all times to act in my best interests. I have had an opportunity to ask any questions about this and understand I can discuss any concerns I have about this at any time.

Signature _____

Print name (in full) _____ Date _____

IntraCare

Intra Limited
E: admin@intracare.co.nz
W: intracare.co.nz
P: +64 9 630 1961 (Monday to Friday 6:30am–6:00pm)
P: +64 27 482 0763 (after hours, weekends and public holidays)

Interventional Cardiology/Radiology patient registration form

Allevia Hospitals

Please return this form **at least one week** prior to your operation/procedure date

My operation/procedure is booked at:

- ☐ Allevia Hospital Epsom (Procedure with IntraCare)
- ☐ Allevia Hospital Ascot (Procedure with Allevia Cardiology Ascot)

Patient details (to be completed by patient)

Title (please circle): Mr Mrs Ms Miss Dr Other _____ Date of birth: / /

Legal first name(s): _____

Family name: _____

Previous name: _____

Gender: _____ Is this the same as your sex assigned at birth? Yes ☐ No ☐

If 'no', what was your sex assigned at birth? _____

Country of birth: _____ NZ resident: Yes ☐ No ☐ NHI number (if known): _____

Residential address: _____

Postal address (if different from above): _____

Preferred contact number: ( )

Email: _____

Ethnic group: _____ Language spoken: _____

Interpreter required: Yes ☐ No ☐ (Interpreter services must be arranged through your specialist's rooms prior to admission)

If visiting from overseas what is your address while staying in New Zealand?

_____ Phone: ( )

Emergency contact person

Name: _____ Preferred contact number: ( )

Relationship to patient: _____

Health insurer

Name of insurer: _____ Policy type: _____

Membership number: _____ Prior approval number: _____

Is your surgery covered by ACC? Yes ☐ No ☐ ACC approval granted: Yes ☐ No ☐

ACC claim number: _____

GP

Name: _____

Practice: _____

Referring medical practitioner (If different from GP)

Name: _____

Practice: _____

Specialist

Name: _____ Date of admission: / / Time of admission: _____

Prescription cards

- ☐ High Use Health Card Expiry date: /
- ☐ Prescription Subsidy Card Expiry date: /
- ☐ Community Services Card Expiry date: /
- ☐ Other Expiry date: /

Interventional Cardiology/Radiology patient registration form (continued)

Allevia Hospitals

Enduring power of attorney (EPOA) for personal care and welfare

Do you have an EPOA for personal care and welfare activated: Yes ☐ No ☐

Attorney full name:

Relationship to patient: Phone:

(If your EPOA has been activated, please provide a copy with your admission forms.)

Personal property

You understand and agree that Allevia Hospitals is not and will not be responsible for loss of or damage to any personal property (including jewellery, dentures, watches, rings, glasses) which you may bring into the hospital.

Sharing information

You consent to Allevia Hospitals sharing relevant information that is related to your healthcare and as required by third parties such as health insurers, medical specialists, ACC, and for quality and audit purposes.

To the best of your knowledge the information you have supplied to Allevia Hospitals is correct.

Signature:

Print name (in full): Date: / /

Please return this form **at least one week** prior to your operation/procedure date

You can email this form or see page 15 of patient information booklet for more details.

Allevia Hospital Epsom
ÍntraCare
admin@intracare.co.nz

Allevia Hospital Ascot
Allevia Cardiology Ascot
procedurebookings@alleviacardiology.co.nz

iAAH1206 03/26

Interventional Cardiology/Radiology patient health questionnaire

Allevia Hospitals

Please return this form **at least one week** prior to your operation/procedure date

My operation/procedure is booked at:

☐ Allevia Hospital Epsom (Procedure with IntraCare)

☐ Allevia Hospital Ascot (Procedure with Allevia Cardiology Ascot)

Dear Patient

The information requested in this form will help us assess your needs and plan your care for your booked admission to Allevia Hospitals. All information will be treated in strict confidence.

When answering the questions, please do not write 'see my notes' or words to the same effect because we will not have all your clinical notes. Please answer as accurately as possible.

Please answer **all questions** on each page even if you think they are irrelevant to your circumstances.

Please bring any mobility aids, CPAP machines etc. to the hospital. If you develop any coughs, colds, infections or wounds before your admission, contact your specialist prior to your admission.

We look forward to helping you prepare for your operation.

Admissions Unit nurses

Patient details

Legal name: _____ **Date of birth:** (dd/mm/yy) / /

Planned procedure: _____

Date of surgery: / / **Best contact phone number:** ( )

Height: _____ cm **Weight:** _____ kg This information is important. **Do not leave this blank.** If you do not know, an estimate is acceptable.

Do you have any allergies? Yes ☐ No ☐

Are you allergic/sensitive to any: (circle which and describe below)

Medications **Foods** **Latex** **Plasters/tape/skin preparations** (e.g. iodine, chlorhexidine) **Other**

Substance	Reaction

Interventional Cardiology/Radiology patient health questionnaire (continued)

Allevia Hospitals

Medications

Do you regularly use any medications? Yes ☐ No ☐ If '**yes**', please provide details in the table below.

Please list **ALL** medicines – tablets, inhalers, patches, injections etc. prescribed by your doctor **or over the counter** (include any herbal or natural remedies). **If you require more space, attach an additional sheet**.

Name of medication	Dose	Frequency

Please bring all your medications, in original packets, with you to hospital.

Do you take any of the below blood thinning medications? Yes ☐ No ☐

☐ Clopidogrel (Plavix) ☐ Warfarin (Marevan or Coumadin) ☐ Dabigatran (Pradaxa) ☐ Rivaroxaban (Xarelto)
☐ Apixaban (Eliquis) ☐ Ticagrelor (Brillinta) ☐ Dipyridamole (Pytazen) ☐ Prasugrel (Effient)
☐ Enoxaparin (Clexane) ☐ None of these

Has your specialist advised you to withhold this medication prior to your surgery? Yes ☐ No ☐

If '**yes**', please provide details:

Do you take any medicines for weight loss (i.e. Ozempic, liraglutide, semaglutide) Yes ☐ No ☐

If '**yes**', which medicine/s:

Have you been taking opioids (i.e. morphine, oxycodone) for a period of more than 3 months? Yes ☐ No ☐

If '**yes**', which medicine/s:

Do you take any medicines to treat opioid dependence (i.e. methadone, Suboxone®), alcohol dependence (i.e. naltrexone) or to aid in smoking cessation (i.e. Contrave®)? Yes ☐ No ☐

If '**yes**', which medicine/s:

Have you ever had a multidrug resistant (antibiotic resistant) organism (i.e. MRSA, ESBL, VRE, CPO/CRE, CRAB, Candida Auris)? Yes ☐ No ☐

If '**yes**', please provide details including date:

Have you been a patient or worked in an **overseas** hospital in the last 12 months? Yes ☐ No ☐

If '**yes**', which country: Approximate date:

Have you been a patient for one or more nights in any **New Zealand** hospital in the last 12 months? Yes ☐ No ☐

If '**yes**', when: Hospital/s:

Have you been a resident in a rest home or long-term care facility (e.g. rehab facility) in the last 12 months (excludes independent living in a retirement village)? Yes ☐ No ☐

Have you lived or travelled outside of New Zealand or Australia in the last 12 months? Yes ☐ No ☐

If '**yes**', which countries: Approx. date of return or arrival to New Zealand:

Have you ever had previous surgery? Yes ☐ No ☐

Interventional Cardiology/Radiology patient health questionnaire (continued)

Allevia Hospitals

Please list **all** major heart or relevant previous admissions to this procedure. Please include where and when (estimate if unsure). **If you require more space, attach an additional sheet.**

Previous surgery	Hospital	Year

Do you have, or have you ever had, any of the following?

Suffered post-op nausea and vomiting with recent surgeries? Yes ☐ No ☐

If '**yes**', please provide details:

Have you or a blood relative ever had any problems during or after anaesthesia? e.g. malignant hyperthermia, muscular dystrophy Yes ☐ No ☐

If '**yes**', please provide details:

Problems opening your mouth? Yes ☐ No ☐

If '**yes**', please provide details:

Are you or could you be pregnant? Yes ☐ No ☐

If '**yes**', please provide details:

COPD/emphysema: Yes ☐ No ☐

If '**yes**', please provide details:

Asthma: Yes ☐ No ☐

If '**yes**', please provide details:

Persistent cough: Yes ☐ No ☐

If '**yes**', please provide details:

Shortness of breath: Yes ☐ No ☐

If '**yes**', please provide details:

Obstructive sleep apnoea: Yes ☐ No ☐

If '**yes**', do you use a CPAP or other sleep apnoea device? Yes ☐ No ☐

High blood pressure controlled with medication: Yes ☐ No ☐

If '**yes**', please provide details:

Heart attack: Yes ☐ No ☐

If '**yes**', please provide details: Date:

Heart murmur: Yes ☐ No ☐

If '**yes**', please provide details:

Artificial heart valve: Yes ☐ No ☐

If '**yes**', please provide details: Date:

Chest pains/angina: Yes ☐ No ☐

If '**yes**', please provide details: Date:

Coronary angiogram or stents in the heart: Yes ☐ No ☐

If '**yes**', please provide details: Date:

Rheumatic fever: Yes ☐ No ☐

If '**yes**', please provide details: Date:

Interventional Cardiology/Radiology patient health questionnaire (continued)

Allevia Hospitals

Atrial fibrillation/palpitations/arrhythmias: Yes ☐ No ☐

If '**yes**', please provide details:

Cardiac devices e.g. pacemaker, ICD: Yes ☐ No ☐

If '**yes**', please provide details:

Stroke/TIA: Yes ☐ No ☐

If '**yes**', please provide details: Date:

Anaemia: Yes ☐ No ☐

If '**yes**', please provide details:

Bleeding disorders: Yes ☐ No ☐

If '**yes**', please provide details:

Blood clots in legs or lungs (DVT/Pulmonary embolism): Yes ☐ No ☐

If '**yes**', please provide details: Date:

Epilepsy/seizures: Yes ☐ No ☐

If '**yes**', please provide details: Last seizure date:

Blackouts/fainting: Yes ☐ No ☐

If '**yes**', please provide details: Date:

Diabetes: Yes ☐ No ☐

☐ Type 1 ☐ Type 2

If '**yes**', do you take any of the following medications?

☐ Insulin ☐ Empagliflozin (Jardiance) ☐ Empagliflozin + Metformin (Jardiamet) ☐ Dapagliflozin (Forxiga)

☐ Canagliflozin (Invokana) ☐ Dapagliflozin + Metformin (Xigduo XR) ☐ None of these

Has your specialist advised you to withhold this medication prior to your surgery? Yes ☐ No ☐

If '**yes**', please provide details:

Kidney problems: Yes ☐ No ☐

If '**yes**', please provide details:

Hepatitis: Yes ☐ No ☐

If '**yes**', please provide details:

Liver cirrhosis: Yes ☐ No ☐

If '**yes**', please provide details:

HIV/AIDS: Yes ☐ No ☐

If '**yes**', please provide details:

Tuberculosis: Yes ☐ No ☐

If '**yes**', please provide details: Date:

Any mental health issues: Yes ☐ No ☐

If '**yes**', please provide details:

Any cognitive issues (i.e. Dementia/Alzeimer's): Yes ☐ No ☐

If '**yes**', please provide details:

Arthritis: Yes ☐ No ☐

If '**yes**', please provide details:

Joint implants or metalware: Yes ☐ No ☐

If '**yes**', please provide details:

Interventional Cardiology/Radiology patient health questionnaire (continued)

Allevia Hospitals

Do you currently use any mobility aides (i.e. Crutches, walking stick or wheelchair): Yes ☐ No ☐

If '**yes**', please provide details:

Have you had any falls within the last 6 months? Yes ☐ No ☐

If '**yes**', please provide details: Date:

Heartburn/reflux: Yes ☐ No ☐

If '**yes**', please provide details:

Bowel conditions: Yes ☐ No ☐

If '**yes**', please provide details:

Bladder conditions: Yes ☐ No ☐

If '**yes**', please provide details:

Current skin problems e.g. ulcers, wounds, eczema, boils: Yes ☐ No ☐

If '**yes**', please provide details:

Do you have difficulty with your sight, hearing or communication? Yes ☐ No ☐

If '**yes**', please provide details:

Do you have any other medical conditions not already covered, or is there anything else we should know about you e.g. Parkinson's, muscle/nerve disease? Yes ☐ No ☐

If '**yes**', please provide details:

Do you or have you ever smoked? Yes ☐ No ☐

If '**yes**', how much? For how long? When did you give up?

Do you or have you ever vaped? Yes ☐ No ☐

How often did you have a drink containing alcohol in the past year?

☐ Never ☐ Monthly or less ☐ 2–4 times a month ☐ 2–3 times a week ☐ 4 or more times a week

How many standard drinks containing alcohol do you have on a typical day when you are drinking?

☐ 1–2 ☐ 3–4 ☐ 5–6 ☐ 7–9 ☐ 10 or more

How often do you have 6 or more drinks on one occasion?

☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily/almost daily

Do you use recreational drugs? Yes ☐ No ☐

If '**yes**', what type? How often?

Do you have any special dietary requirements? Yes ☐ No ☐

If '**yes**', please provide details:

Do you have any religious beliefs/practices or cultural needs we should be aware of? Yes ☐ No ☐

If '**yes**', please provide details:

Interventional Cardiology/Radiology patient health questionnaire (continued)

Allevia Hospitals

Discharge planning

Being prepared for your discharge is just as important as being prepared for your admission. As part of your discharge plan we will anticipate the day of discharge prior to your arrival at the hospital. This will relieve your anxiety and help you be ready for your discharge home.

You will need someone to stay with you for 12-24 hours after discharge.
This may be longer depending on your surgery.

Please complete the section below so we can see what care and support you will need to ensure a safe and speedy recovery.

Carer support

Current living arrangements?

☐ Live alone ☐ Live with others i.e. partner/children

Do you have caring responsibilities for others at home? Yes ☐ No ☐

If '**yes**', please provide details:

Discharge/transport

Please advise the person collecting you that the discharge time for overnight stay patients is **10am**.

Name: Contact phone number (mobile/landline):

Please feel free to add any further comments/concerns regarding discharge:

It is important to know **who** has **completed this form**. Please print and sign your name.

Name (print): Date: / /

Signature:

I am the: ☐ Patient ☐ Legal guardian ☐ Parent ☐ Other (specify):

Please complete and return this form as soon as you receive it, to help us plan your upcoming operation/procedure.

You can email this form or please refer to the information booklet for more details.

Allevia Hospital Epsom
ÍntraCare
admin@intracare.co.nz

Allevia Hospital Ascot
Allevia Cardiology Ascot
procedurebookings@alleviacardiology.co.nz

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Interventional Cardiology/Radiology patient health questionnaire