

UNDER TAKING TO PAY OVERSEAS PATIENT AGREEMENT

SECTION A – PERSONAL DETAILS

Surname _____ Mr/Mrs/Miss/Other _____
Forname(s) _____ Date of Birth _____
Maiden Name _____ Passport No:(if not British) _____
NI or Social Security no _____ Nationality _____

UK Temp address details

House and/or street details _____
Town _____ County/State _____
Country _____ Post or ZIP code _____
Tel no: Home _____ Work _____ Mobile _____

Overseas address details (if not a UK national and/or not ordinarily resident in the UK)

House and /or street details _____
Town _____ County/ state _____
Country _____ Post or ZIP code _____
Tel. No: Home _____ Work _____ Mobile _____

Employer's details

Name and address _____
Town _____ County/State _____
Country _____ Post or ZIP code _____

Does your employer sponsor your private medical insurance –Yes ___ No ___

If you have answered yes, please provide the details of your employee benefits administrator:

Name: _____ Tel No: _____

SECTION B – NEXT OF KIN INFORMATION

Surname _____ Mr/Mrs/Miss/Other _____
Forname(s) _____ Relationship _____
House and/or street details _____
Town _____ County/State _____
Country _____ Post or ZIP code _____
Tel. No: Home _____ Work _____ Mobile _____

SECTION C – INSURANCE DETAILS

I hereby authorise the Trust, or its authorised agents, to make enquiries with my insurers to confirm the extent of, and the limits to, my health insurance policy. My insurance details are:

Insurers name and address _____
Town _____ County/State _____
Country _____ Post/ZIP code _____
Name of personal benefits administrator: _____
TEL No: _____
Insurance policy no _____ Ins claim no _____

Notwithstanding the provisions of my personal undertaking, I agree to assign to the Trust any of my rights to be paid hospital or other related charges by my insurers in respect of the current episode of treatment provided. Should there be any shortfall in payment by the insurer I understand that and agree to accept full responsibility. I also unreservedly authorise disclosure of any medical notes including the provision of copies thereof to my insurer as part of their claim and payment processing requirements.

SECTION D – GUARANTOR DETAILS

I, (insert full name and title) _____

Of (insert house and/street details) _____

Town _____

County/State _____

Country _____ Post/ZIP code _____

TEL No Home _____ Work _____ Mobile _____

Undertake to pay any and all charges of admission of the above named to the hospital as a overseas/private patient, or a patient subject to NHS charges, irrespective of the outcome of the treatment. I also accept full liability for any shortfall in payment effected by the insurer. I am over 18 years of age.

SECTION E – FOREIGN GOVERNMENT, EMBASSY, OR HIGH COMMISSION AS GUARANTOR (complete only if your government is paying for your treatment)

Full name and title of responsible Embassy or High Commission representative: _____

Name of mission _____

Address of mission e.g.: London _____

Embassy or High Commission reference no: _____

Letter of guarantee attached _____

SECTION F – PATIENT/GUARANTOR DECLARATION

I FULLY UNDERSTAND THAT BEING INSURED DOES NOT MITIGATE MY LEGAL RESPONSIBILITY TO SETTLE THE ACCOUNT RENDERED IN FULL AND WITHIN THE TERMS STIPULATED- I.E. WITHIN 7 DAYS. I UNDERSTAND THAT THE ACCOUNT WILL BE REFERRED TO THE TRUST'S RECOVERY AGENTS. IF UNPAID IMMEDIATELY THEREAFTER AND THAT ALL THE ABOVE DETAILS WILL BE MADE AVAILABLE TO THE **RECOVERY LEGAL SERVICES**. THIS AUTHORITY IS UNCONDITIONAL AND IRREVOCABLE.

NOTE: FOR THE PURPOSES OF SECURITY, THE TRUST RESERVES THE RIGHT TO INSTRUCT AN APPROPRIATE AGENCY TO VERIFY THE PATIENTS ADDRESS. SUCH AN ENQUIRY WILL BE RECORDED ON THE AGENCY'S FILE AND MAY BE SHARED WITH OTHER USERS. I ALSO UNDERSTAND THAT IF I AM NOT A BRITISH PASSPORT HOLDER AND/OR AM NOT ORDINARILY RESIDENT IN THE UK, THE TRUST AND/OR LEGAL RECOVERY SERVICES RESERVE THE RIGHT TO CONTACT BRITISH GOVERNMENT MISSIONS ABROAD FOR THE PURPOSES OF CONFIRMING AND/OR VERIFYING THE INFORMATION PROVIDED BY ME REGARDING MYSELF, NEXT OF KIN, GUARANTOR, AND/OR SPONSORS FOR VISA PURPOSES.

I FURTHER UNDERSTAND THAT SUCH CHARGES DO NOT INCLUDE THE SERVICES OF A MEDICAL OR DENTAL PRACTITIONER UNDER WHOM I AM ADMITTED AND TO WHOM I HAVE ARRANGED TO PAY SEPARATE FEES.

I AGREE NOT TO BRING JEWELRY AND OTHER VALUABLES INTO THE HOSPITAL. I UNDERSTAND THAT RESPONSIBILITY FOR ANY SUCH LOSSES RESTS SOLELY WITH MYSELF AS THE HOSPITAL DOES NOT PROVIDE INTERNAL SECURITY IN RESPECT OF SUCH ITEMS.

SIGNED: _____ DATE _____

NAME IN FULL _____

Witnessed by (name) _____

Witness` signature _____ DATE _____

SECTION G – NOTES

1. This section should be completed by the patient or his or her representative who is willing to accept FULL responsibility on the patient's behalf. (Guidance can be sought)
2. Minors must NOT sign this agreement
3. All charges are subject to the provisions of section 65 (3) of the National Health Service Act 1977 or as may be subsequently amended
4. This undertaking must be signed only by an individual accepting personal liability. It must not be signed by a TRUST, Charity, Limited Co, Partnership, Limited Liability Partnership, or any other corporate body.
5. This document is an agreement to pay for any and all hospital charges and is legally binding.
6. Should you be in any doubt concerning any of the above provisions, please ask for a detailed explanation.