

**NAVAL HOSPITAL  
CAMP PENDLETON, CA 92055-5008**

**COLLECTION FORM - PLEASE READ AND SIGN**

The Naval Hospital is required by law to charge active duty members, dependents, retired officers and certain other categories of patients specified rates for each day of hospitalization as follows:

<u>Patient Categories</u>	<u>Per Diem Inpatient Rate</u>
Active Duty	\$ 8.10 per day
Retired Officers	\$ 8.10 per day
Dependents of Retirees/Active Duty Dependents (Not Tricare Prime Enrolled)	\$12.72 per day
All Others	Variable Rate

Charges for inpatient care are due/payable when discharged from the hospital. The day of admission, regardless of the time, is considered a chargeable day at the per diem rate, while the day of discharge is not chargeable. If the admission and discharge take place on the same day, a daily per diem rate will be charged regardless of the number of hours hospitalized. Payments may be made to the Collection Agent, located on the Ground Floor. If the Collection Office is closed at the time of discharge, a bill will be sent to your current address.

For periods of extended hospitalization, payment may be made to the Collection Agent each pay period of the month until paid in full if arrangements are made with the Collection Office, telephone 725-5733 or 725-6484.

Active duty members may pay subsistence charges upon discharge or request a voluntary pay checkage. Active duty members failing to do this will have their pay checkaged involuntarily for the recoupment of subsistence charges.

**IF PAYMENT OF DEPENDENT HOSPITAL CHARGES HAVE NOT BEEN SATISFIED WITHIN 30 DAYS, AN INVOLUNTARY PAY CHECKAGE WILL BE SENT TO SPONSOR'S COMMAND (DISBURSING OFFICER) TO HAVE MONIES REMOVED FROM SPONSOR'S PAY.**

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I have read and completed this statement and understand that daily charges will be applied to my account during my hospital stay.

\_\_\_\_\_  
DATE

\_\_\_\_\_  
WITNESS

\_\_\_\_\_  
PATIENT OR SPONSOR SIGNATURE

# PATIENT ADMISSION HEALTH INSURANCE INFORMATION

Do you have a health insurance policy? \_\_\_\_\_ Yes \_\_\_\_\_ No

If you answered yes, you are required to complete the following information:

**THIS INFORMATION IS PROTECTED UNDER THE PRIVACY ACT OF 1974.**

Policy Holder's Name: \_\_\_\_\_ Policy Holder's SSN: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Patient's FMP: \_\_\_\_\_

Sponsor's Name: \_\_\_\_\_ Sponsor's SSN: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Health Insurance Carrier: \_\_\_\_\_

Address: \_\_\_\_\_

City, State \_\_\_\_\_

Telephone: \_\_\_\_\_

PATIENT'S EMPLOYMENT STATUS (Check One) Employed: \_\_\_\_\_ Retired: \_\_\_\_\_

## PATIENT

I certify that the above information is true and accurate to the best of my knowledge. I hereby authorize and request that proceeds of any and all benefits be paid directly to the Uniformed Service Facility or any other authorized representative of the United States for hospitalization and professional services provided me and/or my dependents.

SIGNATURE: \_\_\_\_\_

DATE SIGNED: \_\_\_\_\_

## FOR OFFICIAL USE ONLY

REGISTER NUMBER: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

TREATING DOCTOR: \_\_\_\_\_

DIAGNOSTIC CODE: \_\_\_\_\_

ROUTINE/EMERGENCY/SAME DAY SURGERY (CIRCLE ONE)

ADMISSION DATE: \_\_\_\_\_

REVIEWED BY: \_\_\_\_\_ SIGNATURE: \_\_\_\_\_

(PRINT NAME)

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**NAVAL HOSPITAL CAMP PENDLETON ADVANCE DIRECTIVES  
QUESTIONNAIRE**

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**TO BE COMPLETED BY ADULT PATIENTS**

Check all boxes that apply.

I have the following Advance Directive:

- A written Health Care Directive (Living Will) and wish to have a copy included in my medical record for the physician to act upon. My Health Care Agent for these purposes is \_\_\_\_\_  
A current copy is located at \_\_\_\_\_
- A Durable Power of Attorney for Health Care, or other advance directive identifying a health care agent, and wish to have a copy included in my medical record for my physician to act upon. My Health Care Agent for these purposes is \_\_\_\_\_  
A current copy is located at \_\_\_\_\_

I do not have a written Advance Directive and:

- I request further information regarding advance directives.
- I do not desire any information at this time.

I acknowledge having received written information about Naval Hospital Camp Pendleton's policies regarding my rights to accept or refuse medical treatment and to formulate advance directives. I understand that the formulation of an advance directive is a personal decision and is not required as a condition for treatment at this medical treatment facility.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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**THIS SECTION FOR USE BY HOSPITAL STAFF**

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Please provide the following information. Check all boxes that apply.

- ADVANCE DIRECTIVE INFORMATION GIVEN TO THE PATIENT.
- ADVANCE DIRECTIVE INFORMATION NOT GIVEN TO THE PATIENT. (STATE REASON \_\_\_\_\_)
- COPY OF PATIENT'S ADVANCE DIRECTIVE RECEIVED BY ADMISSION CLERK.

Signature of Clinic/Admissions Clerk: \_\_\_\_\_ Date: \_\_\_\_\_

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ADDRESSOGRAPH

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