Hopewell Hospice
Healthcare with Heart

Hopewell Hospice

PO Box 1290
Runaway Bay Qld 4216
Provider No: 56050T
Code CR23 FO 1.4.1

Contact
Hospice Manager
Executive Director
Hospice Reception
P: 07 5563 2930
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Estimate For Hospice Services

Date:

RESIDENT Surname:	**Given Names**:	
Address:		**Postcode:**
Date of Birth:	**Marital Status**:	**Gender:**
Health Fund:	**Member No:**	**Table:**
Admission Date:		

HOSPICE QUOTATION

Fees Per Day	Estimated Cost	Fund Rebate	Hospice Contribution	Resident Cost
Accommodation	$600.00			
Admission Fee				$500.00
Consumables (after 2 months)				$50.00 per week
Total				$500.00

Please Note:

This quote is an estimate only, based on information provided prior to admission by the resident, nominee and/or referring hospital and does not include any unforseen treatment which may incur costs.

Prescribed pharmacy items (e.g. medications) ordered for residents by Hospice staff are dispensed by Amcal Pharmacy at Arundel and will be charged directly to the nominee who opens the pharmacy account.

After two months, a fee of $50.00 per week will be levied toward the cost of consumables. (Consumables to include but not limited to local phone calls, Foxtel, dressings and supplies).

Health Fund Excesses will be absorbed by the Hospice while the accommodation is NOT deemed NHTP. The Hospice reserves the right to review these arrangements and if deemed NHTP a charge for the gap or part thereof will be required. Hopewell Hospice issues a duplicate of all invoices sent to Health Funds.

Nominee **Name:** _____ **Relationship:** _____

Address: _____ **Postcode:** _____

Phone 1 _____ **Phone 2** _____ **Mobile** _____

Financial Consent: Resident / Nominee / Next of Kin to Complete

I _____ have read and understand the estimate as per above.

I undertake to pay Hopewell Hospice for the Admission Fee; the required pharmaceuticals from the Amcal Pharmacy at Arundel; and extra consumables (after two months) at a cost of $50.00 per week.

Signature _____ **Nominee Relationship** _____ **Date** _____

For Hospice Office Use Only

Prepared By _____ **Position** _____

Signature _____ **Date** _____

ESTIMATE OF FEES

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