For mat No. 7 (Paragraph 1, Article 9)

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|---|---|---|
| Consultation item number | Dept. | No. |
| Admission permission number | Dept. | No. |

# Admission Application Form

/ / (DD/MM/YYYY)

To the Director of Yokohama Municipal Citizen's Hospital

(Postal code)

Applicant Address Phone No.

Name

Relationship to the patient Phone No.

Employment

This is an application for hospitalization of the following person.:

| | | | | |
|---|---|---|---|---|
| Patient | Name | Date of birth: / / (DD/MM/YYYY) ( years old) | Sex | Male/Female |
| | Address | Phone No. | | |
| | Employment or contact details | Phone No. | | |
| | Head of household | | Relationship | |

I hereby swear that I will abide by the rules of the hospital upon admission, follow the instructions given, cause no problems regarding payment of the expenses and other matters, and fulfill my obligation with my guarantor in case of any violations.

/ / (DD/MM/YYYY)

Name of patient (seal)

Joint guarantor (☐ Details provided on the back of the form)

Address Phone No.

Name (seal)

Employment Phone No.

Note:
1. If the patient is a dependent due to being a minor or for other reasons, the person with the duty to provide support must write the name under the patient's name.
2. Joint guarantor must be **an adult with a separate income from the patient**. In principle, the form must be completed with the **Signature** of the guarantor.
3. Information on this form, including address, name, and contract details, may be used for purposes such as operations concerning medical consultation and notification of late payment of medical expenses.
4. Please use a **black ballpoint pen** to complete this form. Do not use an **erasable pen**.
5. Please use **your respective seal** for the (seal) section of the patient and the joint guarantor.

* If you have a credit card, the card number may be registered in place of appointing a joint guarantor. Please check the box in the joint guarantor section (☐Details provided on the back of the form) and fill in the necessary sections on the back of the form.

**Confirmation of credit card details**

If you have a credit card, the card number may be registered in place of appointing a joint guarantor. Please check the box "□ Details provided" in the joint guarantor section on the front of this admission application form and fill in the necessary items below (credit card does not have to be under the patient's name, as long as the card is registered under the name of the card owner).

Please be advised that if the medical expense is not transferred within seven days from the date of the invoice, payment will be made using the credit card registered below regardless of whether this is the preferred method of payment (receipt and the customer's copy of the card transaction will be sent by post at a later date).

## Confirmation of Credit Card Number and Payment Application (for admission application)

(*Please check either of the following boxes)

☐ I hereby submit the credit card number as a guarantee at admission (payment method will be confirmed again at the time of discharge).
However, I consent to payment being made with the following card in case the payment of medical expense associated with hospitalization is delayed.

☐ I apply to have the medical expenses generated by this hospitalization paid using the following credit card (payment will be made automatically after issuing the account).

| | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Applicant (card owner)<br>Name<br>(Relationship to the patient: ) | | | | | | | | | | | | | | | | |
| Card No. | | | | | | | | | | | | | | | | 16 digits |
| Expiry date | / (MM/YY) | | | | | | | | | | | | | | | |
| Card type | VISA / MASTER / JCB / AMEX / NICOS / DINERS (circle one) | | | | | | | | | | | | | | | |
| Payment method<br>(circle one) | | Single payment | | | Two installments | | | Single payment at the time of bonus income | | | | | | | | |
| | | Revolving payment | | | Installments (3/5/6/10/12 installments) | | | | | | | | | | | |
| Invoice address (*Fill in only if different to the patient address)<br>(Address with postal code)<br><br>(Name) | | | | | | | | | | | | | | | | |

* Payment will be made by a single payment if the payment method is not specified. Revolving payment and installments may be unavailable depending on the card you are using. Also, the preset usage limit cannot be exceeded.

[Section for administrative procedure] General information -> Inpatient section

Name of person received; _____ Card processing date: / / (DD/MM/YYYY) Name of the person in charge: _____