National University Hospital

RESTRICTED, SENSITIVE (NORMAL)

APPLICATION FOR ZOOM CREDIT/ DEBIT CARD ARRANGEMENT

SECTION 1: PATIENT'S PARTICULARS

Name (in BLOCK letters): ______________________________

NRIC/ Passport No: ______________________ Contact No: ______________

SECTION 2: CREDIT/ DEBIT CARD AUTHORISATION

By submitting this form, I confirm that I have read and agree to the ZOOM Terms and Conditions*. I consent to National University Hospital (S) Pte Ltd's collection and disclosure of my personal data to third parties (including the patient) for the purposes of processing this application, processing of refunds and collection of payments. I hereby authorise National University Hospital (S) Pte Ltd to debit my credit/ debit card for any outstanding bills incurred in full by the above mentioned patient and I agree that this authorisation will supersede all prior payment arrangement setup in the system for the patient and shall remain in force unless otherwise revoked by me/ patient in writing.

Cardholder Name : ______________________________

Credit/ Debit Card Type (Please tick accordingly): ☐ VISA ☐ MASTERCARD

Card Number : ☐☐☐☐ - ☐☐☐☐ - ☐☐☐☐ - ☐☐☐☐

Card Expiry Date : ☐☐ / ☐☐ (MM / YY)

Cardholder contact details: Mobile No. ______________ Home No. ______________

Address : ______________________________

Relationship to Patient : ☐ Self ☐ Spouse ☐ Children ☐ Others (Please indicate) : ______________

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Signature of Cardholder

For Official Use Only.
Verified by Staff (Name/ Signature/ Date)

***ZOOM Terms & Conditions**

1. Please complete this ZOOM application form and submit by scanning QR code on the right to upload an image of this completed form.
2. Once the payment arrangement is approved, deductions will be made in full settlement of any outstanding bills incurred by patient.
3. This payment arrangement applies to all charges in the invoices issued in Specialist Outpatient Clinics (SOC)/Rehabilitation Centre/ Dept of Dietetics/ Dept of Diagnostic Imaging (X-Ray)/ Pharmacy (prescribed medication only) for the above named patient. Such invoices will be sent to the patient's address in our records within 7 working days from the date of visit.
4. The hospital reserves the right to terminate this payment arrangement at any time should the account not be maintained in good standing.
5. If we are unable to make the deduction or settlement with your nominated card/ bank for any reason, you/ patient will be required to pay the bills by alternative payment modes immediately. We will not be liable for any charges incurred in your card/ bank account as a result of the deductions.
6. Due to processing lead time, the transaction date reflected in your Credit Card statement may not be the same as the patient's visit date.
7. This payment arrangement will remain in force until otherwise terminated by you/ patient in writing. Please email to payment@1fss.com.sg to discontinue this arrangement.