London Health Sciences Centre

Business Office, PDC Building
339 Windermere Road, PO Box 5339
London, Ontario, Canada N6A 5A5

PATIENT SERVICES, SUPPLIES & DEVICES CHARGE SLIP

DISPENSING DEPARTMENT

☐ University Hospital ☐ Victoria Hospital

Business Unit: _____ Department Code: _____ Account Code: _____

Prepared by: _____ Extension: _____

If possible, patients will be required to pay for item(s) before dispensed. Rates subject to change without notice.

ITEM DESCRIPTION	QTY.	FEE ($)	SUBTOTAL
ABDOMINAL BINDER - Small		44.50	
ABDOMINAL BINDER - Medium		51.50	
ABDOMINAL BINDER - Large		69.00	
AIR CAST LINER (All sizes)		43.50	
AIR CAST WALKING BOOT - Short		141.50	
AIR CAST WALKING BOOT - Long		163.00	
ASSISTIVE DEVICES (shoe horns, sock aids, long handle sponge, etc.)			
BREAST PUMP KIT - Single		26.00	
CIRCUMCISION - Routine Newborn		200.00	
COLLAR - CERVMAX (including replacement pads)		86.50	
COLLAR - MIAMI J		106.50	
COLLAR - PHILADELPHIA		62.00	
CRUTCHES INCLUDING TIPS & PADS		29.00	
FIBERGLASS CAST			
HINGED POST-OP KNEE BRACE		263.00	
IMMOBILIZER - KNEE			
IMMOBILIZER - VELPEAU SHOULDER		17.50	
PESSARY		70.00	
POST OP SHOE		15.50	
PREMIER WRIST BRACE		23.50	
PREMIER WRIST BRACE W/SPICA		26.00	
REACHER			
SPLINT			
T.E.D. STOCKINGS		26.00	
OTHER ITEMS / SERVICES:			

Total Amount: $

WORKPLACE SAFETY & INSURANCE BOARD (WSIB), if applicable

Claim Number: _____ Date of Accident (YYYY/MM/DD): _____

Employer: _____ Area of Injury *(eg. left knee)*: _____

PAYMENT OPTIONS

Supplies or devices CANNOT be returned for refund, credit or exchange.

Please choose one of the following:

☐ Cheque payable to: **London Health Sciences Centre**

☐ Cash or debit card transaction. Option only available at Business Office. Open Monday to Friday, 8:00 am to 3:30 pm.

☐ **Credit Card** (please check one)**:** ☐ VISA ☐ MasterCard ☐ American Express

Credit Card Number: _____ 3 digit code: _____ (on the back of credit card, to the right of signature strip) Expiry Date: _____

Name of Card Holder: _____ Signature: _____

☐ Bill to patient (minimum $10.00 will be charged).

I understand I am financially responsible for item(s) / service(s) received and agree to pay the charges incurred.

_____ DATE (YYYY/MM/DD)

_____ SIGNATURE OF PATIENT / DELEGATE

DISTRIBUTION: **WHITE** - Business Office (Submitted to Business Office through interhospital mail.)
CANARY - Patient's Copy (Given to Patient in order for payment to be processed.)