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PATIENT REGISTRATION INFORMATION

Bay Street MEDICAL
LIVING ON THE HEALTHIER SIDE OF LIFE

Have you ever been a patient or made an appointment at ☐ Princess Margaret Hospital ☐ Doctors Hospital ☐ Rand Memorial Hospital			
Title ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐ Other _____		Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other _____	
Name (LAST, FIRST, MIDDLE INITIAL)			Medical Union Number
Permanent Address		City	Island / P. O. Box
Home Phone Number		Cell Phone Number	
Email Address		Special Needs ☐ Diabetic ☐ Wheelchair ☐ Visually Impaired ☐ Hearing Impaired	
Alternate Home Address		Alternate Home Phone Number	
Dates you will be at this address	National Insurance Number	Date of Birth (dd/mm/yy)	Sex ☐ Male ☐ Female
Occupation		☐ Full Time ☐ Part Time ☐ Student ☐ Retired _____ dd/mm/yy	
Employer		Employer Phone No.	Corporate Sponsored Physical? ☐ Yes ☐ No
Address		City	State / Zip
Race	Ethnicity ☐ Choose Not to Disclose ☐ Hispanic ☐ Non-Hispanic / Religion	Language	Interpreter Needed ☐ Yes ☐ No
Preferred Pharmacy Name Area City Island			Pharmacy Phone Number

SPOUSE OR NEAREST LIVING RELATIVE

Name (LAST, FIRST, MIDDLE INITIAL)	Language	Home Phone Number Cell Phone Number		Relationship
Address ☐ CHECK IF SAME AS ABOVE		City	State	Zip
Additional Contact Name ☐ CHECK IF INTERPRETER NEEDED		Phone Number	Relationship	

PRIMARY INSURANCE INFORMATION*

INSURANCE EFFECTIVE DATE _____

Insurance Company Name		Group No.	Precertification Phone Number
Claim Address		City	State / Zip
Employer of Subscriber	Subscriber's ID No.	Subscriber's Relationship to Patient	Subscriber's Date of Birth

PLEASE ATTACH A COPY OF THE FRONT AND BACK OF ALL ACTIVE INSURANCE CARD(S) AND YOUR DRIVER'S LICENSE.

ADDITIONAL INSURANCE INFORMATION

INSURANCE EFFECTIVE DATE _____

Insurance Company Name		Group No.	Precertification Phone Number
Claim Address		City	State / Zip
Employer of Subscriber	Subscriber's ID No.	Subscriber's Relationship to Patient	Subscriber's Date of Birth

AUTHORIZATIONS AND SERVICE TERMS

MEDICAL RECORD NUMBER	NATIONAL INSURANCE NUMBER
PATIENT NAME	BIRTH DATE

AUTHORIZATIONS

AUTHORIZATION FOR TREATMENT: I consent to the rendering of medical care which may include routine diagnostic procedures and such medical treatment as my attending physician(s) or other Bay Street Medical staff consider to be necessary. I understand that my medical care and treatment may be provided by physicians, including fellows and residents, medical and allied health students, physician assistants, nurses, and other health care providers. I have read and understand this Authorization for Treatment and understand that no guarantee or assurance has been made as to the results that may be obtained.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION*: I authorize Bay Street Medical to release all medical information as necessary to:

- All Payers** for processing health care claims;
- The person(s) I designate as my Billing Addressee/Guarantor for handling the billing, payment, and health care coverage for my account;
- Accrediting and quality organizations, regulatory agencies, or other persons or entities for health care operations;
- My other health care providers for treatment or payment purposes; and
- Affiliated entities of Bay Street Medical for the purpose of providing information regarding the services and goods of Bay Street Medical and/or its affiliates that may be of interest to me. I understand that, if this information is disclosed to a third party, the information may no longer be protected by government privacy regulations and may be redisclosed by the person or entity that receives the information in accordance with applicable law. Bay Street Medical may not condition treatment, payment, enrollment, or eligibility for benefits on your agreeing to this provision.

AUTHORIZATION TO ASSIGN BENEFITS AND RELEASE INFORMATION TO BAY STREET MEDICAL: I authorize my Payer(s) to pay directly to Bay Street Medical any benefits due under the terms of my health care plan(s) for services provided by Bay Street Medical. I understand Bay Street Medical reserves the right to refuse or accept assignment of medical benefits. If my health care plan(s) will not allow direct payment to Bay Street Medical or if Bay Street Medical chooses not to accept assignment of medical benefits, I agree to pay Bay Street Medical all health care payments I receive for services. I authorize Bay Street Medical to contact my Payer(s) to obtain all pertinent financial information concerning coverage and payments made under my health care plan(s) and for my Payer(s) to release such information to Bay Street Medical.

SERVICE TERMS

STATEMENT OF FINANCIAL RESPONSIBILITY: I acknowledge I am responsible for all charges for services provided, including any amount not paid by my health care plan(s). This also applies if I am covered by National Insurance Board (NIB), a health maintenance organization (HMO), workers' compensation policy, or any other payer. Bay Street Medical may participate in certain government programs and does comply with applicable billing terms and restrictions. I agree that Bay Street Medical may obtain financial information, including consumer credit reports to determine eligibility for financial assistance and/or payment options. Information on financial assistance is available by contacting Bay Street Medical at (242) 326-5230.

DISPUTE RESOLUTION: I agree that any dispute (including personal injury claims) related to health care services rendered by Bay Street Medical is subject to the exclusive jurisdiction of the appropriate court in the Commonwealth of The Bahamas where the provider of the disputed services is physically located when the services are rendered and the law thereof. Any court action must be venued in Nassau, Bahamas where the provider of the disputed services is physically located when the services are rendered. These agreements also apply to my legal representatives and next of kin.

USE OF CELL PHONE: I agree Bay Street Medical may use an automated telephone dialing system to contact the cellular telephone number(s) that I provide to Bay Street Medical for appointment and payment purposes.

ATTENTION: Changes will not be accepted on this form. Requests for alterations must be made by calling Bay Street Medical at (242) 326-5230. This is a legal document. By signing, you agree that you understand and accept the terms on this form. I understand I have the right to revoke the authorizations on this form at any time by notifying Bay Street Medical in writing, except to the extent that Bay Street Medical has already taken action in reliance upon them. These authorizations will remain valid until I revoke them in writing.

- **If the patient is 18 years of age or older,** the patient must sign and date the form.
- **If the patient is 18 years of age or older and is incapable of signing,** a legal authorized substitute may sign and date the form.

Please indicate your legal authority and include documentation of your relationship:

☐ **LEGAL GUARDIAN OR CONSERVATOR** ☐ **HEALTH CARE AGENT** (HEALTH CARE POWER OF ATTORNEY) ☐ **OTHER LEGAL REPRESENTATIVE**

- **If the patient is 17 years of age or younger,** the patient's parent or legal guardian must sign and date the form, unless an exception exists under government law.

Please indicate your relationship: ☐ **PARENT** ☐ **LEGAL GUARDIAN**

SIGNATURE	SIGNATURE DATE	SIGNATURE TIME

PRINTED NAME OF PERSON SIGNING (IF NOT PATIENT)

* Medical Information includes, but is not limited to, information related to psychologic, psychiatric, sickle cell anemia, HIV/AIDS, communicable diseases, genetic testing, and alcohol and drug abuse diagnosis and treatment if such information exists.

** For purposes of this form, Payer(s) includes, but is not limitedd to, Insurance carriers, health plan administrators, or any other payers including Union and their agents or review agencies.

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