BAPTIST MEDICAL GROUP

PATIENT REGISTRATION

MRN ____________________________

Date ______________ Referring Physician __________________________ Primary Care Physician ______________________

Patient Last Name ______________________ First Name ___________________ Middle Initial _____ Suffix _____ (Jr/Sr/II etc.)

☐ Male ☐ Female Date of Birth ______/______/______ Soc. Sec. # ____________________________

Physical Address _______________________ City __________________ State ______ Zip __________ County ______________

Mailing Address ________________________ City __________________ State ______ Zip __________ County ______________

Home phone ____________________ Work phone ______________________ ext. _______ Cell phone ____________________

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced Patient E-mail Address ______________________________

Preferred Language: ☐ English ☐ Spanish ☐ Other __________________________ Need Interpreter? ☐ Yes ☐ No

Ethnic Background: ☐ Hispanic/Latino ☐ Not Hispanic/Not Latino ☐ Other ________________________________

Race: ☐ Ame. Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ White/Not Hispanic ☐ Other ________________

Employer: ________________________________ Employer Address ____

Employment Status: ☐ Full Time ☐ Part Time ☐ Not Employed ☐ Retired ☐ Active Duty Military ☐ Disabled ☐ Student FT/PT

Job Title: ____

Is this visit due to an accident? ☐ Y ☐ N If yes, explain: ____________________________ Is this visit job related? ☐ Y ☐ N

Date of injury: ______/______/______ Supervisor name: _________________________ Phone: ________________________

Emergency Contact

Name _______________________________________ Relationship ___________________ Phone ________________________

Responsible Party Information

Name ____________________________________ Home phone _____________________ Cell phone ______________________

Relationship to patient ______________ ☐ Male ☐ Female Date of birth: ______/______/______ Soc. Sec. # _________________

Address _________________________________ City _________________________ State __________ Zip ________________

Employer ____ Employer Address ____

Employment Status: ☐ Full Time ☐ Part Time ☐ Not Employed ☐ Retired ☐ Active Duty Military ☐ Disabled ☐ Student FT/PT

Primary Insurance

Insurance Co. ______________________________________

Group # ________________ Policy # ___________________

Subscriber ____

Relationship to Patient: _________________ Date of Birth: ___/___/___

☐ Male ☐ Female Soc. Sec. # __________ Phone __________

Employer ____

Address ____

____
Signature of patient or person authorized to sign for patient

Secondary Insurance

Insurance Co. ______________________________________

Group # ________________ Policy # ___________________

Subscriber ____

Relationship to Patient: _________________ Date of Birth: ___/___/___

☐ Male ☐ Female Soc. Sec. # __________ Phone __________

Employer ____

Address ____

Date ________________________

BAPTIST MEDICAL GROUP

AUTHORIZATION TO LEAVE MESSAGES

Patient Last Name ____________ First Name ____________ Middle Initial _____ Suffix _____ (Jr/Sr/II etc.)

Address ____________ City ____________ State ________ Zip ____________

Date of Birth _____/_____/_____

Which of the following communications means are appropriate/acceptable for BMG to communicate with you: (please check all that apply)

☐ Home phone # ____________ ☐ Okay to leave a message? ☐ Yes ☐ No

☐ Cell phone # ____________ ☐ Okay to leave a message? ☐ Yes ☐ No

☐ Work phone # ____________ ☐ Okay to leave a message? ☐ Yes ☐ No

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Which method of communication is preferred? ☐ No contact ☐ Mail ☐ Phone ☐ Email ☐ Mychart

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With whom may we share information about your health? Please list below.

Note: In order for BMG to disclose your Private Health Information, the representative listed must be able to provide (2) two of the (3) identifiers listed below:

1. Last 4 digits patient's social security number **2. Patient's date of birth** **3. Patient's zip code**

AUTHORIZATION TO DISCLOSE HEALTHCARE INFORMATION

Name	Relationship to You	Telephone Number	May Discuss Diagnosis/Treatment	May Discuss Billing Info
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No

Do you have a legal document that states who will make decisions if you are unable? ☐ Yes ☐ No

If yes, Name ____________ Relationship to Patient ____________

Check one: ☐ Healthcare Proxy/Agent ☐ General Power of Attorney ☐ Healthcare Power of Attorney

If you would like information about appointing a healthcare proxy/agent, please let us know.

I understand that it is my responsibility to update this list in order to keep accurate those authorized persons to discuss and use the patient's healthcare information.

Patient/Legal Representative Signature: ____________ Date: ____________

OFFICE USE ONLY – Document should be Scanned under Ambulatory Auth and Consent Doc type

BMG | BAPTIST MEDICAL GROUP

Authorizations & Acknowledgments

Date: ________________ MRN ________________________

Patient Name: ____
First Middle Last

Acknowledgment of Notice of Privacy Practices

Initial Here ________ I acknowledge that a copy of the Notice of Privacy Practices was provided to me.

General Consent to Treatment and Test

Initial Here ________ I am voluntarily seeking medical treatment. I consent to examination by the physician, nurse practitioner, nurse and other health care professionals at this clinic. I also consent to any medical procedures, x-ray, laboratory tests or other health care services ordered by the health care team. I understand that I may refuse specific treatments or procedures by informing the health care team.

Release of Information

Initial Here ________ I authorize Baptist Medical Group to release any medical information necessary to process payment of my claim.

Assignment of Insurance Benefits and Acceptance of Financial Responsibility

Initial Here ________ I authorize payment directly to Baptist Medical Group for their fees. I understand and agree that if any part of my account is not paid by insurance, I am financially responsible. I also understand that I may qualify for financial assistance for services provided by Baptist Medical Group and that I may request an application to apply for financial assistance. I further understand that the determination of whether I qualify for financial assistance is dependent upon my timely submittal of appropriate financial documentation and my failure to provide any such documentation could affect my ability to qualify for financial assistance.

Communications Regarding My Account

Initial Here ________ I agree that the facility, Medical Financial Services, Inc. or any other collection or servicing agency or agencies retained by the facility or my physicians (together referred to hereafter as "collectors") to collect any money that I owe to the facility may contact me by telephone or text message at any number given by me or that is or becomes associated with me or my account from sources other than me, including but not limited to, cellular/wireless telephone numbers which may result in my incurring fees for the call or text message. I understand, acknowledge and agree that the collectors may contact me by automatic dialing devices and through pre-recorded messages, artificial voice messages or voice mail messages. I further agree that the collectors may contact me using e-mail at any e-mail address I provide to the facility or is otherwise associated with my account.

Destruction of X-ray Images/Graphic Data (MS Patients Only)

Initial Here ________ I hereby authorize the entity to retire x-ray images and other graphic data which may be generated during my care (treatment, testing, or otherwise) four years after the time generated if a proper report is in the medical record.

____
Signature of patient/parent/guardian/person authorized to sign for patient

Date: ________________

NOTICE TO OUR PATIENTS

During the course of your treatment at BMG, your healthcare provider may recommend you to have procedures performed. Specifically, if you are referred to have radiology or certain other imaging services, such as an MRI, CT or PET scan, we want to provide you with information to ensure you are informed of your rights as our patient.

I. You have the right to receive your healthcare services at the provider of your choice.

II. You have the option to use BMG or an alternate healthcare service provider.

III. You will not be treated differently by your BMG healthcare provider if you choose not to use BMG services.

Below is a list of some alternate healthcare service providers:

The Flinn Clinic
1300 Wolf Park Dr.
Germantown, TN 38138

Diagnostic Imaging PC
6401 Poplar Ave
Memphis, TN 38119

Park Avenue Diagnostic
5190 Park Avenue
Memphis, TN 38119

Outpatient Diagnostic Center of Memphis
5130 Stage Rd
Memphis, TN 38134

Diagnostic Imaging Specialists
7420 Guthrie Dr. N # 105
Southaven, MS 38671

Imaging Center
320 S Gloster St
Tupelo, MS 38804

Radiology Clinic
411 Main St S
Amory, MS 38821

Premier Imaging
1207 MS-182
Starkville, MS 39759

Alliance Health Care Services
581 Medical Drive
Clarksdale, MS 38614

Imaging Center
2526 N. 5th Street
Columbus, MS 39705

Please inform your healthcare provider, if you desire to have your procedures performed at a facility other than BMG.

I acknowledge that as a patient of Baptist Medical Group, I have been informed of my rights.

Patient Name (Please Print or Type) ____________________ Date of Service ____________________

Patient Signature ____________________ Date ____________________

Form # 21-100.150 (09/15)

Cancellations and Missed Appointments

Our goal is to provide quality individualized medical care. "Late cancellations" and "No Shows" are barriers for individuals who need access to medical care in a timely manner. We recognize that certain life events make it difficult to notify us of the need to cancel or reschedule an appointment. If you must cancel an appointment, please follow the guidelines below.

Cancellation

To be respectful of the medical needs of other patients please be courteous and notify the clinic when you are unable to show up for a scheduled appointment. We require that you notify the clinic 24 hours in advance. A late cancellation exists when notice to cancel does not occur 24 hours prior to the scheduled appointment time. This timely notification will allow another individual an opportunity to receive treatment. * *Failure to cancel a scheduled appointment in a timely manner will be recorded in the medical record.*

How to Cancel Your Appointment

There are two ways to cancel your appointment. You may call your specific clinic to speak to one of our Customer Service Coordinators to cancel your appointment and reschedule if needed.

If you have signed up for our web-based patient portal, MyChart, you may electronically cancel an appointment as well as request to schedule.* If you have not signed up for MyChart and would like to, please speak to one of our Customer Service Coordinators and they will be happy to help.

Missed Appointments/No Show

A *no show* exists if you fail to appear for a scheduled appointment. * *Failure to appear for a scheduled appointment will be recorded in the medical record.*

- Each missed appointment/no show will be followed up by a clinic representative.
- Three missed appointments and/or late cancellations may result in a $25.00 fee and/or separation from the clinic.

*Please note: Missed appointments are reviewed over a 12-month period. If you need to cancel/reschedule an OB with ultrasound appointments, please contact your specific clinic.

I do hereby acknowledge that I have received and read the guidelines above and have had any portion of the guidelines, which I do not understand, explained to me.

____ Patient/Guardian Signature

__________________________ Date