BAYSIDE REHABILITATION INC.

REGISTRATION FORM

(Please Print)

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name: First: Middle:			❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F
Street address:		Social Security no.:			Home phone no.: ( )
P.O. Box:	City:		State:		ZIP Code:
Occupation:	Employer:				Employer phone no.: ( )
Chose clinic because/Referred to clinic by (please check one box):		❑ Dr.		❑ Insurance Plan	❑ Hospital
❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other	
Other family members seen here:					

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )
Is this person a patient here? ❑ Yes ❑ No			
Occupation:	Employer:	Employer address:	Employer phone no.: ( )
Is this patient covered by insurance? ❑ Yes ❑ No			

Name of **primary** insurance:	Subscriber's name:			Identification no.:
Subscriber's S.S. no.:	Subscriber's Birth date: / /	Group no.:		
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of **secondary** insurance (if applicable):	Subscriber's name:		Identification no.:	Group no.:
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Bayside Rehab or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

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PROVIDER NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures: We use health information about you for treatment, billing, and healthcare operations. Continuity of care is part of treatment and your records may be shared with other providers to whom you are referred. Information may be shared by paper mail, electronic mail, fax, or other methods. We may use or disclose identifiable health information about you without your authorization in several situations, but beyond those situations, we ask for your written authorization before using or disclosing any identifiable health information about you.

Your rights: In most cases, you have the right to look at or get a copy of health information about you. If you request copies, we may charge you a fee. You also have the right to receive a list of certain types of disclosures of your information that we have made. If you believe that information in your record is incorrect, you have the right to request that we correct the existing information.

Our legal duty: We are required by law to protect the privacy of your information, provide this notice about your information practices, follow the information practices that are described in this notice, and seek your acknowledgement of receipt of this notice. If we make a significant change in our polices, we will change our notice and post the new notice in the waiting room.

(You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.)

Complaints: If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request.

If you have any questions or complaints, please contact:
Privacy officer: Office Manager
P.O. Box 149
36082 Lankford Highway
Belle Haven, VA 23306
Phone (757) 442-5222

Acknowledgement of receipt of Notice of Privacy Practices:

Please sign and print your name and date on this acknowledgement form.

Patient Signature: _____ Date: _____

Printed Name: _____

Patient Representative/Legal Guardian, if applicable: _____