BAYVIEW HOSPITAL PRE-ADMISSION FORM

BAYVIEW HOSPITAL

Patient Number
_____

Patient Information

SURNAME:	FIRST NAME:	MIDDLE NAME:
LOCAL ADDRESS: (Full Address - NO Post Office Box Numbers)		
MAILING/OVERSEAS ADDRESS:		
EMAIL ADDRESS:		
HOME PHONE:	CELL PHONE:	I.D #:
DATE OF BIRTH: Day_____ Month_____ Year_____	SEX: ☐ F ☐ M	TITLE: Mr ☐ Mrs ☐ Miss ☐
Have you ever had any treatment at Bayview Hospital before? ☐ No ☐ Yes	If so in what year?_____	

Additional Information

Employment Status: Full-Time ☐ Part-Time ☐ Student ☐ Unemployed ☐ Retired ☐		Employer:	
Employer Number:	Occupation:	Length of Employment:	
Patient's Emergency Contact:	Relationship:	Home phone:	Cell Phone:
Secondary Emergency Contact:	Relationship:	Home phone:	Cell Phone:
Next of Kin's Name:	Relationship:	Address:	
Next of Kin's Contact Information:	Home Phone:	Cell Phone:	Work Phone:
Next of Kin's Employer:	Home Phone:	Cell Phone:	Work Phone:
Next of Kin's Email Address:		I.D #:	
Guarantor's Name:	Relationship:	Address:	
Guarantor's Contact Information:	Home Phone:	Cell Phone:	Work Phone:

Guarantor Employment Status: Full-Time ☐ Part-Time ☐ Self Employed ☐ Unemployed ☐ Retired ☐

TWO FORMS OF IDENTIFICATION: Can be in the Form of Barbados ID# , Passport, Valid Drivers' Licence, Social Security # or National Insurance #
PROOF OF ADDRESS: Can be a utility bill no older than 3 months or a bank statement/credit card letterhead

Patient: ☐ **Trident ID** ☐ **Passport** ☐ **Proof of Address** ☐ **Insurance Card** ☐ **Other**_____

Guarantor: ☐ **Trident ID** ☐ **Passport** ☐ **Proof of Address** ☐ **Other**_____

Doctor/Procedure Info

Date of Admission: (If known)	Preferred Ward: Private ☐ Semi-Private ☐ Suite ☐	**Direct admission ICU** ☐
Doctor:	Surgery:	
Maternity Patient? ☐ Yes ☐ No	Maternity Due Date:	

Health Insurance Information

☐ **Sagicor** ☐ **Guardian** ☐ **Brydens** ☐ **Pan American** ☐ **ICBL** ☐ **Massy** ☐ **Other**_____

SUBSCRIBER'S NAME:

INSURANCE I.D.#:_____ GROUP POLICY#:_____

Assignment of benefits are considered from Barbados based insurance companies, provided that Bayview Hospital receives a written verification at least 24 hours prior to admission, if not the full deposit is required upon admission.

All patients with <u>overseas insurance policies</u> are required to make a minimum deposit of US $3,000.00 on admission and can be increased based on the services required. It is refundable upon receipt of full payment from **the Insurance Company;** provided that Bayview Hospital receives a written guarantee of payment within 24hrs of admission. If no satisfactory guarantee is received within 24hrs, the patient is then fully responsible for direct payment of all hospital charges. All overseas patients and insurance policy's are billed in US dollars of listed cost. **<u>Bayview Hospital reserves the right to refuse to accept a Guarantee of Payment from an insurance company if they have defaulted on payment</u>**

Please see **additional information** overleaf

PLEASE READ CAREFULLY AND SIGN TO ACKNOWLEDGE YOUR AGREEMENT WITH THE TERMS AND CONDITIONS OF YOUR ADMISSION TO BAWIEW HOSPITAL AS A PATIENT

PAYMENTS MADE ON ADMISSION TO BAYVIEW HOSPITAL ARE DEPOSITS AND BASED ONLY ON AN ESTIMATE

1. The pre-payments made to Bayview Hospital are **DEPOSITS,** only, based on an estimate of costs. A complete itemized bill will be issued upon discharge or on the next working business day.
2. Patients whose bills are **less than** their deposits will be refunded the difference.
3. Patients whose bills are **greater than** their deposits will be required to settle these balances upon the receipt of the Hospital Bill.
4. On discharge after 4:30 pm or on weekends, all outstanding hospital payments are to be settled on the next working business day or on receipt of the Hospital Bill/Performa Invoice.

After all financial arrangements have been honored, each patient will receive an **ADMISSION CARD** which **MUST** be presented before admission will be permitted to the Hospital.

Patients who are staying overnight please note that you are charged for the day of admission and not the day of discharge, **provided you leave by midday**. If you leave **after midday** but before 4:00pm, you will be charged for half a day. If you leave **after 4:00pm** you will be charged for a full day.

AGREEMENT

(a) I understand and fully accept that if the need should arise that I require further medical care, I may be transferred to the Intensive Care Unit (ICU) at Bayview Hospital. An additional deposit of **BDS $10,000.00** (US$ for overseas patients) is to be billed to my credit card or on admission to ICU or payment in full on the receipt of the Hospital Bill.

(b) I understand and accept that the selection of a treating Doctor to provide medical or surgical services at Bayview Hospital is my responsibility alone and not the responsibility of Bayview Hospital. The treating Doctor so selected is NOT an employee or agent of Bayview Hospital.

(c) I understand and accept that any person engaged by the treating Doctor to provide necessary additional services for the purpose of my treatment is NOT an employee or agent of Bayview Hospital.

(d) Exclusive of the Hospital and ICU billing, medical fees and all other additional medical services, will be charged by the treating doctor selected (i.e. physician, surgeon or other medical practitioner) or by the provider of such additional services and by the Anaesthetist. The fees for these services MUST be paid at the offices of the respective provider.

(e) I understand that **all balances are to be settled upon the receipt** of the Hospital Bill. Accounts not settled after receipt of the bill, within 60 days, will have an additional monthly finance charge of 2% added to the account. If a credit agreement or payroll deduction order has not been made with Bayview Hospital and should the account remain outstanding for **over 60 days** (or at the end of the month following the month in which services were rendered), my account will be referred to Debt Collection Agency or Attorney.

(f) Once the debt collection process has started collection fees will be added to my account and my credit rating in Barbados may also be affected.

(g) I **agree to pay** the entire balance of the account including but not limited to reasonable legal fees, bailiff fees and any other expenses incurred in the process of collection.

(h) If a credit agreement has not been made with Bayview Hospital and should the account remain outstanding for **over 90 days**, I hereby authorize Bayview Hospital to obtain any information required relative to my credit history and any source is hereby authorized to provide the requested information.

(i) Bayview Hospital is further authorized to disclose to any credit bureau, reporting agency, business or person, such information regarding my credit history as is appropriate and lawful in the circumstance. I agree to compensate and save Bayview Hospital harmless from any and all claims, in damages to or otherwise, arising from any disclosure.

☐ I understand and accept that Bayview Hospital does not offer safe keeping facilities and all personal belongings are left at my own risk.

☐ I understand Bayview Hospital does not accept liability for any loss, theft or damage inclusive of personal vehicle(s) left in the car park facility.

(k) I understand that Bayview Hospital has an Agreement with Medical Training Universities/Colleges to offer students an Observation Programme.
☐ I agree ☐ I do not agree to allow students to observe treatment/clinical care at the Hospital.

(l) I understand that Bayview Hospital has the right to transfer me to the Queen Elizabeth Hospital (QEH) or another facility for management during a National Shutdown of Barbados.

(m) I understand and accept that all firearm, licensed or unlicensed, are strictly prohibited from the Hospital and must be secured prior to admission. I also accept that any firearms discovered in the Hospital will be immediately turned over to the Royal Barbados Police Force.

(n) Bank Charges and other remittance costs/charges are for the account of the customer/payer/client

I have read and agree to the above terms and conditions. The Guarantor agrees to be jointly and severally responsible for any outstanding balances including collection cost. By signing below, the patient or patient's Next of Kin and Guarantor acknowledge and declare that they have read, understood and agreed to the terms and conditions of the Hospital's Pre-Admission Agreement.

Patient Name /Legal Representative (Print): ..... Patient Guarantor (Print): .....

Patient/Legal Representative Signature: ..... Guarantor's Signature: .....

Date: ..... Date: .....

OFFICIAL USE ONLY

Completed with BVH Representative: ..... Date/Time: .....

Reviewed by BVH Representative: ..... Date/Time: .....

A/C Card prepared: ☐ Yes ☐ No Admission Card given: ☐ Yes ☐ No Package Deal: ☐ Yes ☐ No

Date Patient Notified of their Insurance Difference:..... Notified by: .....

Total Deposit Required ☐ Day Unit ☐ Private Room ☐ Semi-private Room ☐ ICU at BVH ☐

Amount approved by Insurance Co. ☐

Patient to pay (before admission) ☐

☐ Cash ☐ Cheque ☐ VISA ☐ Mastercard ☐ American Express ☐ Debit Card

PAYMENT: Date:..... Receipt #: ..... Amount $BVH: ..... Anesthetist: ..... Dr: .....$.....