CAYMAN ISLAND HEALTH SERVICES AUTHORITY
Patient Responsibility Form

Demographic and Insurance details:

Full Name: _____ Middle Name(s): _____

Physical Address: _____ Mailing Address: _____

Date of Birth: _____ Type of Coverage: Self ☐ Insurance ☐

If insurance (Name of insurer): _____

Telephone Number's: (W)_____ (H) _____ Mobile: _____ Insurance ID#: _____

PLEASE INITIAL NOS. 1-4 AND SIGN BELOW

1. **Self-Pay and Financial Responsibility:** **I understand that it is my responsibility to pay for all treatment and services rendered**. If I am unable to pay in full a promissory not outlining a ninety (90) days payment plan will be signed. Failure to meet this obligation will result in my balance transferred to a collection agency. You may further be charged interest, collection fees, legal fees and or court costs to be recovered on an indemnity basis.

I have read and understand the above consent_____(Initials)

2. **Pre-Certification & Financial Responsibility**: I understand that it is the insurer's responsibility to review anticipated courses of treatment. I understand that if the insurer determines that the treatment plan is necessary and appropriately issues certification, the benefits of my health plan will available to me according to my policy terms. However, if certification is denied, benefits may be withheld. I understand that pre-certification may be the responsibility of the patient or financially responsible party and his or her physician. I also understand that I may be financially responsible for any and all related charges incurred as a result of this treatment plan should the insurer either refuse to pre-certify the treatment, or retrospectively determine that specific service was inappropriate, or should the certification occur too late to be valid. I understand that to protect myself from unnecessary personal financial obligation, I must review my obligation with my insurance company and personal physician in advance of my appointment.

I have read and understand the above consent_____(Initials)

3. Assignment of Benefits: In consideration of the services provided to me, I hereby assign and transfer to C.I. Health Services Authority, all medical providers benefits payable and any related rights existing under the insurance policies described (but not to exceed the amount of charges for this period of service). I authorize and direct the insurance company to pay all such benefits to C.I Health Services Authority. I understand that this assignment does not relieve me of any responsibilities I may have for payment of charges not paid by the insurance company.

I have read and understand the above consent_____(Initials)

4. Consent to Release Claims Information: I hereby consent the C.I. Health Services Authority, their employees and agents, to release and disclose all information that has been and that will be received, recorded or compiled by any or all of them concerning my (patient's) medical care and treatment to all appropriate persons for the purpose of treatment, health care operations and evaluating claims for payment or reimbursement for charges and expenses under any public or private reimbursement which may have a bearing on benefits payable by or on behalf of any such person. I (patient) may restrict the use of information with written notice and if agreed to by the C.I Health Services Authority the additional limitations are binding.

I have read and understand the above consent_____(Initials)

I HAVE READ AND FULLY UNDERSTAND THE AUTHORIZATIONS, CONSENTS, AND ASSIGNMENTS PRINTED ABOVE, AND FULLY ACCEPT AND CONSENT TO THOSE THAT APPLY TO ME.

MINOR'S CONSENT: Patients who are unemancipated minors (patients who are under the age of eighteen) must have parent or guardian's signature except in emergency medical care, diagnosis or treatment of a sexual transmitted disease, or treatment of pregnancy.

_____ _____

Parent Signature Guardian or Authorized Representative sign and print

_____ _____ _____ _____

Relationship to Patient Date Time: AM / PM Witness

Adult / Elderly Consent: Please sign below if you are an adult, eighteen, or over 59 years old. Your signature indicates that you fully understand sections 1 – 4 above. Please tick the appropriate box. Over 18 but below 60 years old ☐ Over 59 years old ☐

_____ _____

Patient Signature Guarantor or Authorized Representative sign and print if other than patient

_____ _____ _____

Date Time: AM / PM Witness

MRN Number: _____ **Encounter/Fin Number:** _____