

	Exam Date and Time:	MRN/Jacket:	Patient Registration
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Name: _____
Address: _____ **City, State, Zip:** _____
Home Phone: _____ **Mobile Phone:** _____
Email: _____ **Date of Birth:** _____
Race: _____ **Gender:** _____ **Marital Status:** _____
SSN: _____
Referring Physician: _____

Emergency Contact Information

Name: _____ **Contact Phone:** _____

Insurance

Primary Insurance Plan Name: _____
Policy #: _____ **Group #:** _____
Secondary Insurance Plan Name: _____
Policy #: _____ **Group #:** _____

Relationship to Insured

Insured Name: _____ **Relationship to Patient:** _____
Insured DOB: _____

Auto Accident or Worker's Compensation Information

Is this injury due to accident? Yes No **If yes, what type of Accident?** _____
Accident Date: _____ **Accident State:** _____

Patient Name:	MRN/Jacket #:
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By signing below, I agree to the following for outpatient radiology care provided by

Authorization for Treatment

I hereby consent to and permit the attending physician and other medical staff to provide me treatment and care as may be deemed necessary and available to me during my office visit or outpatient procedure, including but not limited to tests, examinations, local anesthetics, x-rays and medical and surgical treatments, and other necessary procedures.

Release of Medical Information

With this consent, _____ may use and disclose my protected health information for treatment, payment and health care operations as explained in the _____ Notice of Privacy Practices. I also authorize release of my protected health information to _____, the interpreting Radiologist group, government agencies (such as Medicare and Medicaid), insurance carriers, and other providers for treatment purposes. I understand that I may authorize a personal representative to have access to my protected health information as well.

Would you like to authorize a personal representative to have access to your protected health information including your images, films and reports, please list the person's name, DOB and relationship?

Yes No

MEDICAL RECORDS CAN BE RELEASED TO:

Name: _____ Date of Birth: _____ Relationship to Patient: _____

Financial Responsibility

With this consent, I authorize _____ and/or their representatives to review my insurance coverage with my insurance company. I request that payment of authorized benefits be made directly to _____ on my behalf. I fully understand that I am financially responsible for any and all amounts not otherwise paid by my insurance carrier or worker's compensation. I also certify the information, on this form, given by me for payment under Title XVIII (Medicare) is correct and complete.

Notice of Privacy Practices

I acknowledge that I had the opportunity to review the Notice of Privacy Practices. I understand I may request a paper or electronic copy of this policy to keep.

With this consent, _____ may call or email my home or other alternative location and leave messages or voice mail in reference to any items that assist them in carrying out treatment, payment and health care operations, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including test results, among others.

I understand I may revoke my consent in writing except to the extent that _____ has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it may decline to provide treatment to me.

Signature: _____

Date: _____

Printed Name: _____

ULTRASOUND/X-RAY HISTORY FORM

Patient Name: _____

DOB: _____ Age: _____ Height: _____ Current Weight: _____

Have you had a previous imaging study related to this problem? Yes ___ No ___

If yes, what exam? MRI ___ CT ___ Ultrasound ___ X-ray ___ Other _____

What facility? _____

FEMALE PATIENTS ONLY

Some imaging procedures are contra-indicated (not recommended) for patients who may be pregnant. If you may be pregnant, please notify one of our team members. By my signature below, I acknowledge that I have read and understand this statement and state that I am not pregnant and there is no chance that I may be pregnant.

Are you breastfeeding? Yes ___ No ___ Date of last period? _____

ACKNOWLEDGEMENT

I have answered these questions to the best of my knowledge and understand the information presented to me. If I am to have intravenous con-trast with my procedure, I have been informed of the risks.

Patient/Guardian Signature: _____ Date: _____

Technologist's Signature: _____ Date: _____