Memorial Radiology Associates, LLC

REGISTRATION / CONSENT FORM

Today's Date:	Referring Physician:

PATIENT INFORMATION

Patient's last name:	First:
Address:	City/State/Zip code

Last Four of SSN no.:	Home phone no.:	Cell phone no.:	Birth date:	Age:	Sex:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Subscriber's name:	Address (if different)	Home phone:
Group no.:	Policy No.:	Birth date:

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	Other:

Consent

Protected Health Information

I have received a copy of the Notice of Privacy Practices for Protect health (the "Notice"). This Notice provides a complete description of the uses and disclosure of my Personal Protected Health Information ("PHI"). I have had the opportunity to review this information before signing this form. I consent Memorial Radiology Associates and/or any physician(s) participating in my care releasing my PHI (either in writing or verbally) to carry out treatment, payment or health care operations. This includes any medical information which may be needed to process claims for medical insurance benefits relative to this visit. I understand, I may restrict how the (PHI) is use or disclosed. While Memorial Radiology Associates will make every effort to comply with my requests, it is not required to agree with the restrictions.

Financial Responsibilities

We will submit a claim to your insurance company for service(s) provided, regardless of whether we are a participating provider. You will be financially responsible for any co-pay, co-insurance or balance due as stated on the Explanation of Benefits, issued by your insurance plan. I also authorize Memorial Radiology Associates, LLC or insurance company to release any information required to process my claims

Authorization For Consent

This will serve as authorization for Memorial Radiology Associates and the Radiologist(s) to render diagnostic imaging as directed by your referring physician. I acknowledge that no guarantee has been made concerning the medical treatment. A copy of this authorization shall be as valid as the original.

Patient/Guardian signature	Witness Signature	Date