MEMORIAL RADIOLOGY ASSOCIATES, LLC - REGISTRATION FORM

PATIENT INFORMATION:

Patient Legal Name: _____ DOB: ____/____/_____ Marital Status: _____

Address: _____ City: _____ State: _____ Zip: _____

Mobile #: _____ Home #: _____ Email: _____

Family Physician: _____ City: _____ State: _____ Office #: _____

Employer: _____ Employment: ☐ Full-Time ☐ Part-Time ☐ Retired

(Optional) *Preferred Language:* _____ *Ethnicity:* _____ *Race:* _____ *Religion:* _____

EMERGENCY CONSENT INFORMATION:

Name: _____ Relationship to Patient: _____ Phone # & Type: _____

GUARANTOR INFORMATION: IF SELF CHECK BOX ☐

Name: _____ Relationship to Patient: _____ Sex: _____ DOB: _____/_____/_____

Phone # & Type: _____ Address: _____ City: _____ State: _____ Zip: _____

PRIMARY INSRURANCE INFORMATION: *INFORM STAFF IF ADDRESS IS DIFFERENT FOR INSURANCE*

Insurance Co Name: _____ Subscriber ID: _____ Group #: _____

Self: ☐ If Not Self, Subscriber Name: _____ Relationship to Pt: _____ Sex: _____ DOB: ____/____/_____

SECONDARY INSRURANCE INFORMATION: (IF APPLICABLE)

Insurance Co Name: _____ Subscriber ID: _____ Group #: _____

Self: ☐ If Not Self, Subscriber Name: _____ Relationship to Pt: _____ Sex: _____ DOB: ____/____/_____

Protected Health Information: I have received a copy of the Notice of Privacy Practices for Protected 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 used 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.

Signature of Person Completing Form: _____ Date _____/_____/_____