Medical Imaging & Therapeutics
Center for Diagnostic and Interventional Radiology

PATIENT REGISTRATION FORM

PATIENT NAME_____DOB _____

MARITAL STATUS (CIRCLE ONE): SINGLE MARRIED DIVORCED WIDOWED

SEX_____ SS#_____ EMAIL ADDRESS _____

ADDRESS_____

CITY_____ STATE_____ ZIP_____

HOME PHONE _____ CELL _____ WORK _____

EMPLOYER_____ LOCATION_____

PRIMARY INSURANCE_____ SECONDARY INSURANCE_____

INSURANCE POLICY HOLDER AND/OR GUARANTOR (IF OTHER THAN PATIENT)

NAME_____ RELATIONSHIP TO PATIENT_____

DOB _____ SS# _____

ADDRESS_____ CITY _____

STATE____ ZIP_____ HOME PHONE _____ CELL _____

FEDERAL GOVERNMENT MANDATED MEANINGFUL USE PATIENT INFORMATION

This information is optional, and will be come part of your permanent medical record at ***Medical Imaging & Therapeutic, LLC.*** It is used for Federal Government mandated reporting purposes.

PATIENT RACE:
_____American Indian
_____White
_____Black or African American
_____Native American
_____Pacific Islander
_____Asian
_____Declined

LANGUAGE:
_____English
_____Spanish
_____French
_____German
_____Other
_____Declined

ETHNICITY:
_____Hispanic / Latino
_____Non Hispanic / Latino
_____Declined

SMOKING STATUS:
_____Current every day smoker
_____Current some day smoker
_____Former smoker
_____Never smoked

LIST OF CURRENT MEDICATIONS:

_____ _____ _____
_____ _____ _____
_____ _____ _____

DRUG ALLERGIES:

_____ _____ _____

X_____ DATE_____
Patient/Responsible Party Signature

PLEASE COMPLETE BOTH SIDES OF THIS FORM BEFORE RETURNING IT TO THE FRONT DESK

ASSIGNMENT OF BENEFITS:

I understand I am financially responsible for all charges whether or not paid by any insurance company. I hereby authorize Medical Imaging & Therapeutic, LLC to release information as may be requested by my insurance company in order to secure payment. All medical benefits to which I am entitled, including Medicare, private insurance and all other plans shall be paid to Medical Imaging & Therapeutics, LLC for payment of medical services. I further understand that failure to notify our office of appointment cancellation within 24 hours will result in a $50 fee ($150 for MRI or surgical procedure under sedation) which must be paid prior to the next appointment.

X_____ **DATE**_____

Patient/Responsible Party Signature

CONSENT TO RELEASE MEDICAL RECORDS:

I authorize Medical Imaging & Therapeutic, LLC to release certain protected health information (PHI) in the form of diagnostic imaging studies (CD's, electronic images, and/or reports) to my physician(s). The information will be used or disclosed for purposes of treatment, payment, and healthcare operations (TPO).

Additional physicians to receive your report:_____

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION:

I acknowledge that a Notice of Privacy Practices has been made available to me and I have been given the opportunity to review the Notice and Understand my rights under said Notice.

The individuals listed below are allowed full and complete access to my (PHI) to include reports and/or images.

NAME	RELATIONSHIP	PHONE

X_____ **DATE**_____

Patient/Responsible Party Signature

Medical Imaging & Therapeutics, LLC follow all guidelines set forth by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). A copy of the HIPAA Practice is available upon request.

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