TEXAS ADVANCED IMAGING

PATIENT REGISTRATION FORM

Date: _____ Home Phone:_____ Cell Phone:_____
Name: _____ SS#: _____
Address:_____
City: _____ State: _____ Zip: _____
Sex: M F Age:_____ Date of Birth: _____
Patient Employer _____Occupation: _____
Employer Phone_____ EMAIL: _____
In case of emergency, who should we notify? _____ Phone: _____

PRIMARY INSURER

Primary insurer name: _____ Relation to patient: _____
Birthdate: _____ SS#: _____
Address: _____ City: _____ State: ____ Zip: _____
Employed by: _____ Occupation: _____
Business Address: _____ Business Phone: _____
Insurance Company: _____
Contact #: _____ Group#:_____ ID #:_____

PATIENT AUTHORIZED REPRESENTIVE

Please indicate with a yes or no any Authorized representative to whom we may release protected information to, including any reports/films, insurance and or financial information*if you are a legal guardian, or have power of attorney over the patient please list yourself below
Name: _____Relationship:_____Phone:_____ Yes or NO

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s) have insurance and hereby authorize payment directly to the facility all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance, and for all services rendered on my behalf or my dependent(s). I understand that additional costs may be incurred if my insurance company is not contracted with Texas Advanced Imaging, and including but not limited to: no preauthorization by the insurance company, out of network insurance carrier, lack of medical coverage, or not deemed medically necessary, investigative or experimental in nature. I agree to have this examination performed and authorize any holder of medical and/or other information related to me to be released to the above insurance carrier to determine benefits for related services. If the patient is a minor child, my signature represents consent to take all images needed within the modalities of X-ray, MRI, and/or Ultrasound. I have been fully informed of possible safety risks regarding the nature of medical imaging, and hereby give consent for the exam. The above-named facility may use my health care information and may disclose such information to the above-named Insurance Company(s) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. I have received and understand the Notice of Privacy Practices. I authorize the use of my signature on all insurance submissions. This consent will end when my current treatment plan is completed or one year from the date signed below.

Any and all imaging results received by the above named facility will be forwarded to the referring physician's office. Any discussion, concerns or questions regarding results or reports must be discussed with the referring physician.

_____ _____
Signature of Patient, Guardian or Person Responsible **Date**

_____ _____
Please print name of Patient, Guardian, or Person Responsible **Relationship to Patient**