Memorial MRI & Diagnostic IMAGING CENTERS

Registration Form

PATIENT INFORMATION

Name:

DOB: **Gender:** **Age:**

Address:

City: **State:** **Zip:**

Phone Number:

AUTHORIZATION FOR TREATMENT

I hereby consent to treatment by the attending physician and other medical staff for all local anesthetics, tests, surgical and other medical procedures as deemed necessary by myself and the medical staff.

AUTHORIZATION FOR RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby assign to the above-named office; those benefits otherwise payable to me by any third party as reimbursement of expenses and fees in connection with treatment rendered. I request that payment of authorized benefits be made directly to the medical provider, third party, or their assigns, on my behalf.

I FULLY UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY AND ALL AMOUNTS NOT OTHERWISE PAID BY MY INSURANCE CARRIER OR ANY THIRD PARTY.

I certify the accuracy of the information about me and authorize its release to the Health Care Finance Administration or other health care coverage entity, any information needed for this or any related health care claim that I provide in writing or verbally. I further understand and agree to pay for services or amounts due when appropriate. These charges could include amounts applied to my annual deductible co-payment amounts, charges denied as not covered by my insurance program or deemed medically unnecessary, and charges not satisfied through legal processes. I understand that well care is not covered by Medicare or many other health insurance programs.

I authorize the release of information, digital films and images, and copies pertinent to my medical history and for follow-up of my suspicious findings. This consent authorizes Memorial MRI and Diagnostic to release my insurance company, referring physician and other physicians participating in my care, my medical record, including images and reports.

I understand that if I have provided a wireless phone number that I agree to receive phone calls and text messages for appointment reminders and notice of my financial responsibility for treatment provided.

If someone other than the patient is signing this authorization, please state your relationship with the patient and the reason the patient is unable to sign.

_____ _____

Patient Signature **Date**

_____

Authorized Party

Reason:

_____

HIPAA Authorization and Notice of Receipt of Privacy Practices

Name:
DOB:
DATE:

I have been provided access to Memorial MRI & Diagnostics Notice of Privacy Practices.
I understand that I am entitled to a copy of these practices at my request.

I furthermore acknowledge that I have the right to designate access to my Protected Health Information (PHI) to anyone of my choosing. I hereby authorize disclosure of my PHI to the following individual(s) Authorized Individuals:

1.

2.

3.

I request the following restrictions to releasing my PHI:

1.

2.

3.

I understand I may revoke this authorization at any time by submitting a written request to Memorial MRI & Diagnostic's Privacy Officer, as per the office's Notice of Privacy Practices.

I understand that by signing this authorization, this information will be used by Memorial MRI & Diagnostic's to make determinations for the release of my PHI. I also understand this authorization will remain in effect until I request an update and/or amendment.

_____ _____

Patient Signature **Date**

_____

Authorized Party

Reason:

_____
