

Registration Form

PATIENT INFORMATION

Namo:

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

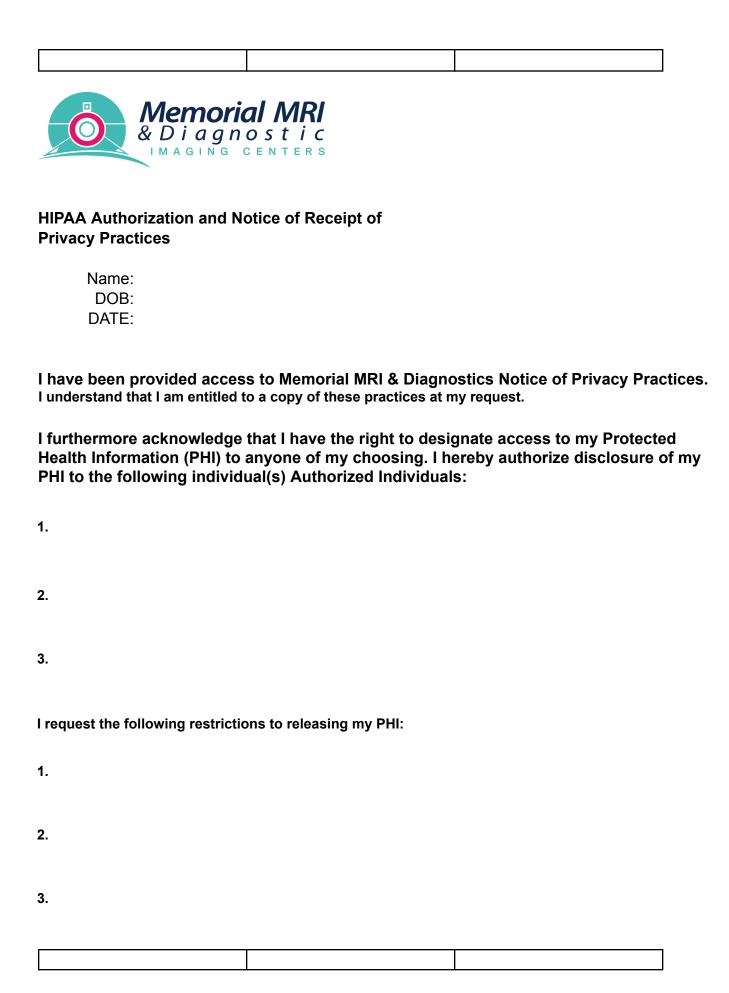
I hereby assign to the above-named office; those benefits otherwise payable to me by any third party as reimbursement of expenses and fees in connection with treatment rendered. I request that payment of authorized benefits be made directly to the medical provider, third party, or their assigns, on my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

•	stand that if I have provided a wireless phone number that I agree to receive phone not text messages for appointment reminders and notice of my financial responsibility atment provided.			
If someone other than the patient is signir with the patient and the reason the patient	ng this authorization, please state your relationship at is unable to sign.			
Patient Signature	Date			
Authorized Party				
Reason:				



Patient Signature Date Authorized Party			
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	written request to Memorial M	RI & Diagnostic's Privacy	-
Authorized Party	Memorial MRI & Diagnostic's	to make determinations f	or the release of my PHI. I
Authorized Party			
	Patient Signature	_	Date
Reason:	Authorized Party		
	Reason:		
			