EXPRESS MEDICAL IMAGING

Patient Registration Form

PATIENT INFORMATION

Last Name:_____ First: _____ Middle: _____

Date of Birth:_____ Sex: _____ SSN: _____

Mailing Address: _____

City:_____State:_____ Zip Code:_____

Home Phone: _____ Cell: _____

Email:_____

_____ ***By placing my initials in the space provided, I verify that I have reviewed the information above and it is correct.***

PRIMARY INSURANCE

Plan: _____ Policy #:_____

Group #: _____ Policyholder's Name: _____

Policyholder's Relationship to Patient: _____ Policyholder's DOB: _____

SECONDARY INSURANCE

Plan: _____ Policy #:_____

Group #: _____ Policyholder's Name: _____

Policyholder's Relationship to Patient: _____ Policyholder's DOB: _____

ACKNOWLEDGEMENT / WAIVER OF LIABILITY

Please initial by each statement below:

_____ I hereby authorize Express Medical Imaging to bill my insurance carrier (s) for services rendered. I further authorize the release of all necessary information including reports, images and outcomes as requested by Insurance Carrier(s).

_____ I understand that charges for all services provided, but not covered by my insurance carrier(s) will be my financial responsibility.

_____ I authorize the release of all or any portion of my medical record to any health care practitioner or facility designated by me. *Image reports will automatically be sent to the ordering physician's office. If you would like this report to be sent to another facility please specify.

_____

Patient or Parent/Guardian Signature: _____ Date: _____