MEMORIALCARE® IMAGING CENTER

PATIENT DEMOGRAPHICS

PATIENT INFORMATION			
Name:	Sex:	Date of Birth:	SS#
Address:	City/State/Zip Code:		
Home Phone:	Cell Phone:	E-mail:	
Name of Responsible Party if Patient is a Minor:			

REFERRING/TREATING PHYSICIAN INFORMATION	
Referring Physician:	**Phone**:
Request to include the following physicians on patient report:	
Name:	Phone:
Name:	Phone:
Name:	Phone:

INSURANCE BILLING INFORMATION	
Primary Insurance:	Relationship to Pt: ___Self ___ Parent ___ Spouse
Subscriber Name:	Subscriber DOB:
Insurance Billing Address:	
ID Number:	Group Number:
Secondary Insurance:	Relationship to Pt: ___Self ___ Parent ___ Spouse
Subscriber Name:	Date of Birth:
Insurance Billing Address:	
ID Number:	Group Number:

WORKER'S COMPENSATION		
Name of Adjuster:	Phone:	Date of Injury:
Billing Address:		Claim #:
Employer Name:	Emp. Phone #:	

EMERGENCY CONTACT	
Name:	Relationship to Patient:
Phone #:	

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign to MemorialCare Imaging Center, all insurance benefits to which I am entitled for services performed by MemorialCare Imaging Center Requested information including medical records may be released to the insurance carrier.

FINANCIAL AGREEMENT

If my insurance company determines that is not reasonable and necessary or not authorized under my insurance policy guidelines, I agree that I will be obligated to pay for the exam. Should my account be referred to an attorney for collection, I understand I will pay reasonable attorney's fees and collection expenses.

NO SHOW POLICY

I understand if I fail to attend a scheduled appointment or cancel at less than 24 hours prior to the appointment, I will be considered a "no show" and may be subject to a "no show" charge per occurrence.

NOTICE OF PRIVACY PRACTICE

I understand that as part of my healthcare, **MemorialCare Imaging Center**, originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment.

I understand I have been afforded the opportunity to receive a copy of the Notice of Privacy Practices from MemorialCare Imaging Center, concerning how the use and disclosure of Protected Health Information is handled by the practice. I understand I have been afforded the opportunity to indicate any restrictions to the use or disclosure of my health information.

CONSENT FOR TREATMENT

I consent to and authorize the administration of all radiological and imaging services considered advisable and necessary in the judgment of my physician. I acknowledge that these services have been adequately explained and all questions have been answered.

RELEASE OF RECORDS

I hereby authorize **MemorialCare Imaging Center**, to release and forward information concerning my medical records to other physicians within my circle of care. Additionally, I authorize to release my medical and/or billing records to the following individuals:

Name:	_____	Relation to Patient:	_____
Name:	_____	Relation to Patient:	_____
Name:	_____	Relation to Patient:	_____
Name:	_____	Relation to Patient:	_____

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed. I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to re-disclosure by the above recipient. I understand I have the right to revoke this consent in writing.

I authorize records to be sent using the appropriate media, including paper, film, fax, telephonic communication, or via secure internet access. I understand that **MemorialCare Imaging Center**, will take reasonable steps to protect my confidentiality and that I may discuss any confidentiality concerns or grievances by calling 949-706-7827.

I authorize MemorialCare Imaging Center to obtain my prior imaging/diagnostic records from another facility or physician, and to also obtain a copy of my laboratory results as they pertain to this exam/s only. The reason for this request is to provide all previous information of my prior imaging and lab history to the radiologists for comparison purposes. I hereby authorize the following facilities and/or physicians to disclose my medical records to **MemorialCare Imaging Center**:

_____

I hereby authorize that **MemorialCare Imaging Center**, may receive information concerning my past or present illness from my other physicians or facilities where I have received treatment. My signature below shall serve as authorization for my other physicians to provide copies of requested medical records.

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

Printed Name of Patient Date of Birth