MRN # ____________

Patient Registration Sheet

Patient Name: ______________________________
Last First M.

Date of Birth: ____________ SSN: ____________

Address: ______________________________
Street Apt # City State Zip

Home Phone: (   ) ____________ Work Phone: (   ) ____________

Cell Phone: (   ) ____________ Email Address: ____________

Language: English Spanish Other: ____________ ☐ Male ☐ Female

Race: Caucasian African American Asian Native American Other: ____________

Ethnicity: Hispanic/Latino Non Hispanic/Latino

How did you hear about Partners Imaging Centers? ____________

AUTHORIZATION FOR ACCESS BY OTHERS TO YOUR PROTECTED HEALTH INFORMATION

Please check all situations below where you would grant individuals listed below access to your PHI:

☐ Confirmation of appointments details ☐ Pick up medical records ☐ Billing information

Last 4 digits of your SSN (this will be used as the pass code to your PHI): ____________

Please list individuals for whom you authorize to access your PHI:

Name: ____________ Relationship: ____________

Name: ____________ Relationship: ____________

Acknowledgement: By submitting this form, I hereby permit Partners Imaging Center , to disclose my PHI to the individual(s) indicated above. I understand that each individual I have listed will be required to provide the pass code I have given in order for the physicians office to release my PHI. In addition, authorized individual(s) must present identification as proof that they are who they claim to be. I also understand that Partners Imaging Center reserves the right to deny access.

____________ ____________
Patient/Parent/Guardian Signature **Date of Authorization**

Our policy is to collect any deductible/copay/coinsurance that may be due at time of service. The amount collected is not a final payment - we only collect a portion based on your benefits & eligibility provided by your insurance company.

INSURANCE VERIFICATION

Ins Co Name: ____________ ID #: ____________

Phone #: ____________ Ref #/Representive: ____________

Auth Needed: Yes No Auth #: ____________ Exp Date: ____________

Ded Amount: ______ Amt Met: ______ Coinsurance %: ______ Copay $: ______

Out of Pocket: ______ Effective: ______ Active Policy: Yes No Verified: ______

(Auto or W/C) DOI: ______ Claim #: ______

Claims Mailing Address: ____________

Attorney Info: ____________