PATIENT REGISTRATION FORM

Please Print Legibly

PATIENT INFORMATION

Today's Date	Referring Doctor	

Last Name	First Name	Middle Name

Street Address	Apt #	City	State	Zip Code

Home Phone Number	Sex	Date of Birth	Age	Marital Status	Social Security Number
					- -

Employer's Name or School	How Long Employed?	Phone Number

Employer's / School's Street Address	City	State	Zip Code

GUARDIAN OR RESPONSIBLE PARTY INFORMATION

Last Name	First Name	Middle Name

Street Address	Apt #	City	State	Zip Code

Home Phone Number	Sex	Date of Birth	Age	Marital Status	Social Security Number
					- -

Employer's Name or School	How Long Employed?	Phone Number

Employer's / School's Street Address	City	State	Zip Code

SPOUSE INFORMATION

Spouse's Last Name	First Name	Middle Name

Home Phone Number	Sex	Date of Birth	Age	Marital Status	Social Security Number
					- -

Employer's Name or School	How Long Employed?	Phone Number

Employer's / School's Street Address	City	State	Zip Code

NAME OF FRIEND, RELATIVE, GUARDIAN OR PARENT (not living with you) - *for medical emergency*

Last Name	First Name	Relation to Patient	Home Phone #

Street Address	Apt #	City	State	Zip Code

Employer's Name or School	How Long Employed?	Phone Number

INSURANCE INFORMATION

	Primary Insurance Carrier	Secondary Insurance Carrier
Insurance Company Name		
Street Address		
City, State, Zip Code		
Policy / Certificate / ID Number		
Group Number		
Policyholder's Name		
Policyholder's Date of Birth		
Policyholder's Relationship to Patient		

Please complete the reverse side of this form.

AUTHORIZATION FOR REQUEST OF MEDICAL RECORDS

I hereby authorize my physicians to release information from my record verbally, via fax or mail to Radiology Specialists of the Northwest, PC including diagnosis and test results which may include drug and/or alcohol, psychological conditions or Acquired Immunodeficiency Syndrome.

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby authorize Radiology Specialists of the Northwest, PC to release information from my medical record (including diagnosis and test results which may indicate drug and/or alcohol, psychological conditions or Acquired Immunodeficiency Syndrome.

I certify that information given by me is correct. I hereby authorize payments directly to Radiology Specialists of the Northwest, PC of the insurance benefits otherwise payable to me. I understand I am financially responsible to Radiology Specialists of the Northwest, PC for any charge not covered by this authorization.

CONSENT TO TREATMENT AND TESTS

I have been referred for care (treatment, testing, or otherwise) at Radiology Specialists of the Northwest, PC. I permit Radiology Specialists of the Northwest, PC and its employees, and others involved in my care to provide testing, services or care that is beneficial to me, under the orders or direction of my physician. I have the right to ask questions and receive information about my care and treatment, and the right to withdraw my consent.

I acknowledge and agree that NO Guarantees have been made to me as to the results or outcome of my treatment, testing and/or other care.

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF INSURANCE BENEFITS

The undersigned jointly and severally agree, in consideration for the services rendered to the below named patient, to accept financial responsibility and agree to pay Radiology Specialists of the Northwest, PC for its charges for services rendered to the patient. Even though insurance benefits have been assigned to provider, the undersigned clearly understands and agrees to pay the Provider's bills or unpaid balance of the bill due. If this account should be placed in the hands of a collector or attorney for collection, fees (which shall equal one-third of any balance due), court cost and other expenses will be paid by the undersigned in addition to the bills. Notice of dishonor, demand and protest is waived.

As partial security for the services to be rendered to me, I do hereby unconditionally assign all payments of insurance benefits to which I may be entitled because of this period of medical treatment, up to and including Provider's regular and customary charges for services rendered to me. It is understood that this assignment includes all health insurance policies owned by me regardless of whether the policy contemplated direct payment to me or to the Provider and further covers all claims that I may have against any third party who was legally responsible for the injuries or illnesses which are the cause of this period of medical treatment.

I certify that the information given by me in applying for payment under Titles XVII and XIX of the Social Security Act, or under other insurance coverage is correct. I request that payment of authorized benefits be made on my behalf to Radiology Specialists of the Northwest, PC. I transfer and assign to Radiology Specialists of the Northwest, PC and to other entities providing special services which may be covered by the third party payer, all of my rights to benefits payable to me or to the beneficiary under all applicable policies of insurance or health plan(s) listed with the facility at registration, and those not listed and which are listed and which are later determined to provide coverage. By this assignment, I authorize payment directly to Radiology Specialists of the Northwest, PC. It is my responsibility to take action necessary for such benefits to be paid to Radiology Specialists of the Northwest, PC. If a third party or its insurer is liable to me for my injuries or expenses, including my Radiology Specialists of the Northwest, PC charges, I authorize and direct such third party and insurer to withhold from any settlement or judgment which I may recover, such sums as are due and owing to the facility for services rendered to me, and such sums are hereby assigned to Radiology Specialists of the Northwest, PC and are to be paid directly to Radiology Specialists of the Northwest, PC by such third party or insurer. I understand that I am fully responsible for charges and this does not relieve me of my personal responsibility to pay for the charges when due.

DATE ____________________ SIGNED ______________________________________
(Patient's Signature or Parent/Guardian Signature)