The Imaging Center at Wolf River	Exam Date and Time:	MRN/Jacket:	Patient Registration

Name: ____________________

Address: ____________________ **City, State, Zip:** ____________________

Home Phone: ____________________ **Mobile Phone:** ____________________

Email: ____________________ **Date of Birth:** ____________________

Race: __________ **Gender:** __________ **Marital Status:** ____________________

SSN: ____________________

Referring Physician: ____________________

Emergency Contact Information

Name: ____________________ **Contact Phone:** ____________________

Insurance

Primary Insurance Plan Name: ____________________

Policy #: ____________________ **Group #:** ____________________

Secondary Insurance Plan Name: ____________________

Policy #: ____________________ **Group #:** ____________________

Relationship to Insured

Insured Name: ____________________ **Relationship to Patient:** ____________________

Insured DOB: ____________________

Auto Accident or Worker's Compensation Information

Is this injury due to accident? **Yes** ☐ **No** ☐ **If yes, what type of Accident?** ____________________

Accident Date: ____________________ **Accident State:** ____________________

Patient Name: **MRN/Jacket #:**

By signing below, I agree to the following for outpatient radiology care provided by The Imaging Center at Wolf River

Authorization for Treatment

I hereby consent to and permit the attending physician and other medical staff to provide me treatment and care as may be deemed necessary and available to me during my office visit or outpatient procedure, including but not limited to tests, examinations, local anesthetics, x-rays and medical and surgical treatments, and other necessary procedures.

Release of Medical Information

With this consent, The Imaging Center at Wolf River may use and disclose my protected health information for treatment, payment and health care operations as explained in The Imaging Center at Wolf River Notice of Privacy Practices. I also authorize release of my protected health information to The Imaging Center at Wolf River, the interpreting Radiologist group, government agencies (such as Medicare and Medicaid), insurance carriers, and other providers for treatment purposes. I understand that I may authorize a personal representative to have access to my protected health information as well.

Would you like to authorize a personal representative to have access to your protected health information including your images, films and reports, please list the person's name, DOB and relationship?

Yes ☐ No ☐

MEDICAL RECORDS CAN BE RELEASED TO:

Name: ______________________________ Date of Birth: ___________________ Relationship to Patient: ____________________________

Financial Responsibility

With this consent, I authorize The Imaging Center at Wolf River and/or their representatives to review my insurance coverage with my insurance company. I request that payment of authorized benefits be made directly to The Imaging Center at Wolf River on my behalf. I fully understand that I am financially responsible for any and all amounts not otherwise paid by my insurance carrier or worker's compensation. I also certify the information, on this form, given by me for payment under Title XVIII (Medicare) is correct and complete.

Notice of Privacy Practices

I acknowledge that I had the opportunity to review the Notice of Privacy Practices. I understand I may request a paper or electronic copy of this policy to keep.

With this consent, The Imaging Center at Wolf River may call or email my home or other alternative location and leave messages or voice mail in reference to any items that assist them in carrying out treatment, payment and health care operations, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including test results, among others.

I understand I may revoke my consent in writing except to the extent that The Imaging Center at Wolf River has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it The Imaging Center at Wolf River may decline to provide treatment to me.

Signature: ____ **Date:** ___________________

Printed Name: ____