	Exam Date and Time:	**MRN/Jacket:**	**Patient Registration**

Name: ______________________________

Address: ______________________ **City, State, Zip:** ______________

Home Phone: ______________________ **Mobile Phone:** ______________

Race: ________ **Gender:** ________ **Marital Status:** ______________

SSN: ______________________ **Date of Birth:** ______________

Referring Physician: ______________________ **Email Address:** ______________

Employment Status: **Full Time** **Part Time** **Unemployed** **Retired** **Disabled**

Emergency Contact: ______________________ **Contact Phone:** ______________

Would you like to authorize someone other than yourself to have access to your protected health information including your images, films, and reports? **Yes or No**

If yes, please list their name: ______________________ Their date of birth: ______________

Patient Registration and Consent for Treatment

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, administration of medications, local anesthetics, x-rays and medical and surgical treatments, and other necessary procedures.

Release of Medical Information

With this consent, AUHI may use and disclose my protected health information for treatment, payment and health care operations as explained in the AUHI Notice of Privacy Practices. I also authorize release of my protected health information to 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.

Financial Responsibility

With this consent, I authorize AUHI and/or their representatives to review my insurance coverage with my insurance company. I request that payment of authorized benefits be made directly to AUHI 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

With this consent, AUHI may call, text 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. I understand I may revoke my consent in writing except to the extent that AUHI has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it AUHI may decline to provide treatment to me.

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. **Initial here** _______

I certify that I have read and fully understand all of the above statements and consent fully and voluntarily to its contents.

Signature: ______________________ **Date:** ______________

Printed Name: ______________________