Texas Health Care Imaging

REGISTRATION FORM

Patient's last name:	First Name	Middle

Birth date:	Social Security No:	Age:	Sex	Marital status: Single ☐ Mar ☐ Div ☐ Sep ☐ Wid ☐

Street address:	City/State	Zip Code

Cell No:	Home No:	Work No:	Emergency Contact & Phone#:

INSURANCE INFORMATION	☐ Is this a primary insurance	
Insurance Name:	ID#	Relationship:
Name of insured person:	DOB:	SSN#

2ND INSURANCE INFO	☐ Is this a Secondary Insurance	
Insurance Name:	ID#	Relationship:
Name of insured person:	DOB:	SSN#

ATTORNEY INFORMATION		
Attorney Name:	Phone #	Case Worker Name:

Assignment of Benefits / Treatment & Patient Consent

ASSIGNMENT OF BENEFITS: The above information is true to the best of my knowledge. I understand payment for services are due when services are rendered. I understand that I am financially responsible for any co-pays /deductibles or portions not covered by my insurance. I authorize my insurance benefits **be paid directly to** Texas Health Care Imaging. Please be advised that services performed may incur **other third party charge**s such as: radiologist reading, laboratory, etc. and will be billed by them.

CONSENT: I give Texas Health Care Imaging my consent for treatment. I understand that this treatment consent applies to this all radiological services.

Acknowledgment of Notice of Privacy Practice / Release of Medical Records

I have been presented with a copy of the Notice of Privacy Practices for the office of Texas Health Care Imaging, detailing how my information may be used and disclosed as permitted under federal and state law. I have read the about acknowledgement and agreements, and fully understand the same.

Patient Authorization for Use and Disclosure of Protected Health Information

By signing, I authorize **Texas Health Care Imaging** to use and/or disclose certain protected health information (PHI) about me to ____ (What Dr., Facility, etc.). As allowed by the Health Insurance Portability and Accountability Act (HIPAA) and Department of Health and Human Services regulations.

This authorization permits **Texas Health Care Imaging** to use and/or disclose the following individually identifiable health information about me (specifically describe the information to **be used or disclosed**, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.):

☐**Entire Medical Record** ☐ **Lab Results** ☐ **Operative Report** ☐ **Radiology Services**

☐ **Consult Report** ☐ **Referrals** ☐ **Other:**____

The information will be used or disclosed for the following purpose:

☐ **Continued Treatment** ☐ **Consultation** ☐**REFERRAL TO SPECIALIST** ☐ **OTHER** ________________________________

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is authorized is furnished may not condition its treatment of me on whether or not I sign the authorization. My written revocation must be submitted to the Privacy Officer at: **Texas Health Care Imaging.**

______________________________ ______________________

Patient, Parent or Guardian Signature Date

______________________________ ______________________

PRINT Patient, Parent or Guardian Name Relationship to patient

** **FOR OFFICE USE ONLY** **

______________________________ ______________________

Office staff signature Date

Texas Health Care Imaging

Patient's Name: DOB:

ADVANCE BENEFICIARY NOTICE (ABN) NOTE: You need to make a choice about receiving these health care items or services.

We expect that your Insurance will not pay for the item(s) or service(s) that are described below.

☐ Office Visit ☐ Preventative Services ☐ Automobile accident related services
☐ Laboratory ☐ Other:____

Your insurance probably will not pay for –Items or Services: Because:

State the reason:

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should **read this entire notice carefully.**

- Ask us to explain, if you don't understand why your Insurance probably won't pay.
- Ask us how much these items or services will cost you (**Estimated Cost: $**__________________), in case you have to pay for them yourself or through other insurance.

PLEASE CHOOSE **ONE** OPTION. CHECK **ONE** BOX. **SIGN & DATE** YOUR CHOICE.

☐ **Option 1. YES. I want to receive these items or services.** I understand that my Insurance will not decide whether to pay unless I receive these items or services. Please submit my claim to my Insurance. I understand that you may bill me for items or services and that I may have to pay the bill while my Insurance is making its decision. If my Insurance does pay, you will refund to me any payments I made to you that are due to me. If the Insurance denies payment, **I agree to be personally and fully responsible for payment**. That is, I will pay personally, either out of pocket or through any other insurance that I have.

☐ **Option 2. NO. I have decided not to receive these items or services.** I will not receive these items or services. I understand that you will not be able to submit a claim to the Insurance.

____ ______________________

Signature of patient or person acting on patient's behalf **Date**

NOTE: Your health information will be kept confidential.
Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to your Insurance we may share the health information on this form.