RESILIENCE IMAGING REGISTRATION INFORMATION

PATIENT INFORMATION (PLEASE USE FULL LEGAL NAME)

Last:_____ First:_____MI:_____Sex: _____

DOB:_____ SSN# _____ Marital Status:_____ Home Phone: _____

Address: _____ Cell Phone: _____

City:_____State:_____Zip:_____

Employer:_____Work Phone: _____

Emergency Contact Name:_____Emergency Contact Phone #: _____

RESPONSIBLE PARTY INFORMATION

Name:_____Relationship:_____Phone:_____

Address:_____ DOB_____SSN#:_____

Employer: _____Work Phone #_____

INSURANCE INFORMATION

On the job injury: Yes / No Motor Vehicle Accident: Yes / No Injury Date: _____

Primary Insurance

Insurance Company:_____Policy #:_____Group Number: _____

Policy Holder Name: _____Policy Holder DOB: _____

Adjuster Name / Phone #: _____

Secondary Insurance

Insurance Company:_____Policy #:_____Group Number: _____

Policy Holder Name: _____Policy Holder DOB: _____

RELEASE OF INFORMATION AND PAYMENT AUTHORIZATION

I authorize the release of information necessary to process this claim and assign benefits payable for services directly to Resilience Imaging. I authorize the release of any medical information necessary for treatment by my current or future physician or healthcare provider.

I authorize Resilience Imaging to release to my insurance company any medical information which may be necessary to process my insurance claim. I understand that in the event my insurance company denies this claim I may be held financially responsible for all charges.

I acknowledge that I have read and had the opportunity to receive a copy of Resilience Imaging's Privacy Notice.

Printed Name: _____

Signature: _____ Date: _____

RESILIENCE IMAGING

Patient Authorization

Section I : Receipt Acknowledgement for the Notice of Privacy Practices

I,_____have been made aware of the notice of Privacy Practices for Resilience Imaging. I understand that this notice states how Resilience Imaging may use and disclose my Protected Health Information ("PHI.")

I UNDERSTAND THAT A COPY OF THIS NOTICE IS AVAILABLE UPON REQUEST.

_____*Initial*

Section II: Consent for Treatment

I authorize Resilience Imaging, to perform all exams, tests, procedures, injections and any other care deemed necessary or advisable for the diagnosis and treatment of my medical condition(s.)

_____*Initial*

Section III: Consent for Release & Acquisition of Medical Records

In order to provide the most accurate reading of my current studies and to assure that I am receiving the highest quality of care, I consent to Resilience Imaging obtaining any of my previous images, radiology reports, pathology reports, or results of surgical intervention for comparison to my current studies and to track abnormal results. For the same purpose, Resilience Imaging may release my studies performed at a Resilience Imaging facility to my treating physicians and medical facilities, upon their request.

In order for Resilience Imaging to obtain and release my records in a timely manner, I authorize Resilience Imaging to convey my records and images by Certified Mail, Courier or Electronic Transmission.

Initial

Section IV: Release of Records to a Designated Third-Party

In addition to my treating physicians and medical facilities, I authorize Resilience Imaging to release my records and images to the following individuals. (This should include **friends or family members** responsible for picking up your records when you are unable to do so.) PLEASE PRINT

Name: _____ Phone: _____

Name: _____ Phone: _____

_____*Initial*

Patient Signature:

By signing below I am verifying that I have read each of the four sections on this page. I understand each section and consent to and agree with the information stated in each section.

_____ _____

Patient / Legal Representative Signature **Date**

_____ _____

Patient's Printed Name **Date**