PATIENT REGISTRATION

Please complete the following information so that we can bill your insurance **NORTH PUGET SOUND MRI**

Patient Name_____ Male O Female O
Last *First* *Middle Initial*

Birthdate_____ Age_____

Mailing Address _____
Street apt. no. City State Zip Code

Home Phone_____ Cell_____ Work _____ Email_____

Ok to leave message at O Home O Cell O Work Primary Care Physician:_____

Patient's Employer/School_____ Phone_____

Parent/Spouse/Domestic Partner_____Phone_____

In case of **EMERGENCY**: Relative to contact (other than spouse)_____ Phone_____

INFORMATION ABOUT YOUR CONDITION

What part of the body are you being seen for today?_____ Right O Left O Both O

Prior treatment for this condition: Yes O No O Where/Whom_____

Is this a result of an injury? Yes O **No** O **Date of Injury_____**

How did this happen?_____

If this is work related or auto accident, complete the following:

Claim/Policy#_____ Work Comp Carrier/Auto Insurance_____

Claims Mgr/Adjuster_____ Phone_____

Is there an attorney helping you with your problem? Yes O No O

PRIMARY INSURANCE

Ins.Co Name_____

Subscriber _____DOB:_____

ID#_____GROUP#_____

ANY OTHER INSURANCE

Ins.Co Name_____

Subscriber_____DOB_____

ID#_____GROUP#_____

If someone other than the PATIENT is responsible for payment, complete the following:

Name of responsible party_____Address_____

Relationship to patient_____ Phone_____ DOB_____ Soc Sec#_____

AUTHORIZATION FOR TREATMENT OF MINOR: I authorize North Puget Sound MRI to treat the minor patient named above.

Signature of Responsible Party:_____

NOTICE OF PRIVACY PRACTICE:

We keep record of the health care services we provide you. You may ask to see and copy the record. You may also ask to correct the record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record to get information about it by contacting the administrator of the location at which you have been treated. Please call the main office phone number and ask for the administrator. Our NOTICE OF PRIVACY PRACTICES describes in more detail how your health information may be used and disclosed, and how you can access your information.

Whom may we share your information with including financial account information?

Name:	Relationship:	Phone:
Name:	Relationship:	Phone:

RELEASE OF BENEFIT & INFORMATION

I authorize my insurance benefits to be paid directly to my physician and/or Proliance Surgeons, Inc. I am financially responsible for any balance due, including monthly service charges on patient balances over 60 days.

I authorize the doctor or insurance company to release any information required on this claim.

I acknowledge receipt of the Notice of Privacy Practices.

Signed:_____ Date:_____