Imaging Rochester
Imaging Lakeside
Imaging North Country

PATIENT REGISTRATION FORM
Please print all information

PATIENT NAME :_____

SEX: Male Female BIRTHDATE :_____

ADDRESS :_____

CITY, STATE, ZIP :_____

PRIMARY PHONE :_____

CELL PHONE :_____ WORK PHONE :_____

INSURED POLICY OWNER **(IF ANOTHER PERSON)**

NAME:_____ DOB :_____

PRIMARY CARE PHYSICIAN :_____

EMERGENCY CONTACT :_____

CONTACT INFO :_____

MOTOR VEHICLE ACCIDENT **(YES / NO)** WORK RELATED INCIDENT **(YES / NO)**

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AUTHORIZATION TO LEAVE MESSAGE: I authorize AHI Imaging to leave a message on my phone regarding appointments and billing information ☐ YES ☐ NO

AUTHORIZATION TO RELEASE INFORMATION:

I authorize the release of my medical records to the following **non-referring** physicians:
PHYSICIAN :_____ PHYSICIAN :_____

I authorize disclosure of my health information to the following individuals (spouse, parent, child, etc)

NAME :_____ RELATIONSHIP :_____

NAME :_____ RELATIONSHIP :_____

- I hereby authorize After Hours Imaging, LLC to release or receive any information required in the course of my examination or treatment.
- I was provided HIPAA Compliance information provided on the back of this form.

AUTHORIZATION TO PAY: I hereby authorize payment directly to the business office of After Hours Imaging, LLC for medical benefits, if any, otherwise payable to me for services.
I understand that I am financially responsible for the charges not covered by my insurance.

SIGNATURE: _____ DATE: _____
(Signature of responsible party)

Please review second page and sign HIPAA Consent Form

OFFICE PHONE (518) 593-7466 OFFICE FAX (518) 324-7404

HIPAA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to the restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition receipt of treatment upon the execution of this Consent.
- The patient is entitled to pick up one (1) copy of their report and images 72 hours after their exam. Any additional personal records request will be a fee of $5.00 at time of pick up.

The Consent was signed by: _____
(Signature of Patient or Representative)

Printed Name: _____

Date: _____

Relationship to Patient: _____
(if other than patient)