ahi Imaging, LLC

PATIENT REGISTRATION FORM

Please print all information

TODAY'S DATE: _____

PATIENT INFORMATION

PATIENT NAME: _____ **DATE OF BIRTH:** _____ **SEX**: Male/Female

ADDRESS: _____ **ZIP:** _____

PHONE(S): _____ **REFERRING PHYSICIAN:** _____

PRIMARY CARE PHYSICIAN (IF DIFFERENT THAN REFERRING)**:** _____

RESPONSIBLE PARTY (IF OTHER THAN PATIENT)**:** _____

RELATIONSHIP TO PATIENT: _____

PATIENT INSURANCE

NAME OF INSURANCE POLICY HOLDER (IF OTHER THAN PATIENT)

NAME: _____ DOB: _____

PATIENT'S RELATIONSHIP TO THE POLICY HOLDER: _____

IS TODAY'S VISIT RELATED TO THE FOLLOWING?

WORK RELATED INJURY? YES OR NO **MOTOR VEHICLE ACCIDENT?** YES OR NO

IF YOU ANSWER YES TO EITHER OF THESE QUESTIONS, PLEASE FILL OUT ADDITIONAL FORM

I AUTHORIZE AHI IMAGING TO LEAVE A MESSAGE ON THE PHONE NUMBERS I HAVE PROVIDED ABOVE REGARDING:

☐ APPOINTMENTS ☐ BILLING INFORMATION

HIPAA PRIVACY INFORM

I AUTHORIZE DISCLOSURE OF INFORMATION REGARDING MY

☐ BILLING ☐ APPOINTMENTS ☐ EXAM RESULTS ☐ RELEASE OF IMAGES

TO THE FOLLOWING INDIVIDUAL(S):

NAME _____ RELATIONSHIP _____

NAME _____ RELATIONSHIP _____

NAME _____ RELATIONSHIP _____

AUTHORIZATION TO PAY: I hereby authorize payment directly to AHI Imaging, LLC for medical services received. I understand that I am financially responsible for the charges not covered by my insurance.

AUTHORIZATION FOR: AHI Imaging, LLC to obtain and/or release protected health and medical information in regards to my care and treatment – all prior studies and exams.

SIGNATURE: _____ DATE: _____

(Signature of responsible party)