Patient Registration Form (PLEASE PRINT)

For Office Use Only: Auto____ WC____ Self-Pay____

PATIENT INFORMATION

Patient Full Name: ____ **Patient's DOB**: _______________
Last First Middle Initial

Patient's SSN: ___________________________ **Gender**: M___ F____ **Marital Status**: S___ M___ D___ W___

Street Address: ____

City/State/Zip Code: ____

Phone 1: (_______) _________________________________ Type: Home_____ Cell____

Phone 2: (______) __________________________________ Type: Home_____ Cell____

Ethnicity: Hispanic or Latino ____ Non-Hispanic or Latino ____ Other or Undetermined ____

Race: Asian____ Black or African American____ Caucasian____ American Indian or Alaskan Native____ Chinese____

Pacific Islander____ Native Hawaiian____ Filipino____ Japanese____ Multiracial____ Other____ Undetermined____

Emergency Contact Name:____

Emergency Contact Phone: (____) _________________ **Relationship to Patient**: ___________________________

Email Address: ____

Please indicate below what type of information that may be shared at the email address you have provided above:

All ___ Scheduling/Appointment ____ Billing/Insurance ____ Health Related Newsletter _____ Medical Records ______

Employer: ____

Occupation: ____ Work Phone: (______) ______________________________

Employer Address: ____

City/State/Zip Code: ____

RESPONSIBLE PARTY INFORMATION

Who will be responsible for your account? Self _____ Other _____________________________________
(IF *SELF*, SKIP THIS SECTION)

Responsible Party Name: ____
Last First Middle Initial

Patient's Relationship to Responsible Party: ____

Responsible Party Street Address: ____

City/State/Zip Code: ____

Home Phone: (_______) _______________________________ **Cell Phone**: (______) _________________________

revision date: 10/2014

INSURANCE INFORMATION (Please provide Insurance Card & Photo ID to Front Desk)

Primary Insurance Company Name: ______________________________

Insurance Address: ______________________________

City/State/Zip Code: ______________________________

Phone Number: (_____) ______________________________

Member ID Number: ______________________________ Group Number/Name: ______________________________

Name of Policy Holder: ______________________________
Last First Middle Initial

Policy Holder Date of Birth: __________ Policy Holder's SSN: __________________ Relationship to Patient: __________________

If you have Secondary Insurance, please complete this section:

Secondary Insurance Company Name: ______________________________

Insurance Address: ______________________________

City/State/Zip Code: ______________________________

Phone Number: (_____) ______________________________

Member ID Number: ______________________________ Group Number/Name: ______________________________

Name of Policy Holder: ______________________________
Last First Middle Initial

Policy Holder Date of Birth: __________ Policy Holder's SSN: __________________ Relationship to Patient: __________________

ASSIGNMENT OF BENEFITS OTHER THAN MEDICARE: I hereby assign and authorize payments for services rendered to be paid directly to ProScan Imaging. I understand that my insurance carrier(s) may not approve or reimburse my medical services in full due to usual and customary rates, benefit exclusions, coverage limits, lack of authorization or medical necessity. I understand that I am responsible for any charges not paid in full, co-payments, deductibles and co-insurance except where my liability is limited by contract or state or federal law. A photocopy of this document shall be as valid and as effective as the original.

FOR MEDICARE PATIENTS ONLY: I certify that the information given by me in applying for payment under Title XVII of the Social Security Administration or its intermediaries or carriers is the correct information needed for Medicare claims. I hereby authorize any holder of medical or other information about me to release to the Centers for Medicare & Medicaid Services or its agents, intermediaries or carriers any information needed to determine these benefits or the benefits payable for related services. I further understand that deductibles, coinsurance and any other charges not covered by Medicare are my responsibility.

RELEASE OF MEDICAL INFORMATION: I authorize ProScan Imaging to release the medical records concerning myself or my dependent to any physician, hospital or agency involved in the care of the patient listed on this form.

PAYMENT POLICY: Co-payments, Co-insurance and deductibles will be collected at the time services are rendered. We accept cash, checks, and credit cards. You will be responsible for any balance deemed patient responsibility/non-payable/non-covered by your insurance.

COMMUNICATIONS AUTHORIZATION: I hereby consent to receive auto-dialed and/or pre-recorded telephone calls from or on behalf of ProScan Imaging at the telephone numbers provided above, including my wireless number, if applicable. I understand that this consent is not a condition of receiving services from ProScan Imaging.

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE. I HAVE READ, UNDERSTAND, AND AGREE TO ABIDE BY THE ABOVE RELEASE OF MEDICAL INFORMATION AND PAYMENT POLICIES.

Signature of Patient or Responsible Party: ______________________________ Date: ______________
(if under 18 yrs of age)

revision date: 10/2014

PROSCAN imaging®

The Most Trusted Name in Medical Imaging

Informed Consent for X-Ray Examination

IF YOU ARE PREGNANT OR THERE IS ANY POSSIBILITY YOU MAY BE PREGNANT PLEASE NOTIFY YOUR TECHNOLOGIST!

What is an X-Ray?

An X-Ray examination produces images of the body by using a small dose of ionizing radiation. An X-Ray machine works much like a camera, but instead of using light to expose the film radiation is used. Bone, fat, muscle, and masses absorb radiation at different levels. The X-Ray film is merely a picture of shadows cast by the internal structures within your body.

What happens during an X-Ray exam?

There are 2 ways to perform an X-Ray examination, lying on a table or standing up. The Technologist will determine the manner in which your examination will be performed based on the order from your Physician. The X-Ray film will be placed in the machine underneath, or behind the area to be examined. Whenever possible a lead apron may be placed over your pelvic area or breasts to help protect you from radiation. You will be asked to hold very still during the exam to improve clarity, and depending upon the exam ordered you may also be asked to hold your breath. You may then be repositioned for additional views and the process is repeated. When the examination is complete you will be asked to wait while the technologist determines that they have captured all necessary images for the Radiologist. The entire procedure will take 5 to 15 minutes.

What are common uses of the procedure?

X-Ray examinations are used to diagnose many medical conditions including fractures, dislocations, injury, and infection, abnormal bone growth, detecting bone cancers, and locating foreign bodies in soft tissue.

What are the benefits vs. the risks?

X-Ray examinations are relatively inexpensive and easily accessible and therefore the fastest and easiest way to view and assess many conditions. No radiation stays in the body after the examination and there are usually no side effects from diagnostic X-Ray exams. Special care is taken to ensure the lowest possible radiation dose is used while still obtaining the best images for evaluation.
If you are pregnant or there is any possibility you may be pregnant please notify your technologist!

Alternatives to X-Ray:

Depending on the condition being examined there may be some alternatives to X-Rays. Ultrasound images can be obtained using sound waves to create a picture of structures within the body. Magnetic Resonance Imaging (MRI) uses magnetic fields and radio waves to produce images of body structures. Computed Tomography Scan (CT Scan) uses radiation and computer technology to produce images of body structures

By signing this you agree that you have read this form and/or I have received oral communications of all the information provided in this form. You understand the information, and have had any questions answered regarding this procedure and who will read the exam. In addition, you agree that you 1) have been explained the purpose of the procedure; 2) have been informed of how long the procedure will take; 3) understand the risks, benefits, and complications associated with the procedure; 4) have truthfully informed ProScan of my current medical condition and have complied with any requirements for having this procedure that have been communicated to me; 5) are aware of possible alternatives; and 6) have been given the right to refuse to consent to the procedure.

I have not been pressured to sign this consent and do so voluntarily. I understand that I may contact ProScan at the address and phone number provided if I have any further questions about this form or the procedure. I am at least 18 years of age, of sound mind and not under the influence of alcohol or hallucinogenic drugs. I have no reservations and give my consent to start and complete the exam(s) by my signature and date here.

Patient's and/or Appropriate Agent's Signature ____________________ Date ____________

revision date: 10/2014

Health History Questionnaire for X-Ray Examination

Patient Name ______________________________ Patient Date of Birth ____/____/____

Type of Exam ______________________________ Date of Exam ____/____/____

Please answer the following questions.

1. Is there any chance you could be pregnant? ____ YES ____ NO
2. Date of last menstrual period (LMP): ____/____/____
3. List any surgeries related to your visit today. ______________________________

____

____

Patient Signature: ______________________________ Date: ____/____/____

Technologist Notes Hx: ______________________________

____

____

Patient Was Shielded: ___ YES ___ NO Tech Initials: _____

HIPAA Acknowledgment & Office Policies

BY SIGNING BELOW, I HEREBY ACKNOWLEDGE AND AGREE TO THE FOLLOWING POLICIES:

RESPONSIBILITY FOR VALUABLES. ProScan does not assume responsibility for securing any and all valuables and personal items belonging to patients or visitors. You are responsible for securing all valuables or personal items prior to your imaging exam.

**I have read and understand the above statements and acknowledge that ProScan and its employees are not liable for the loss or theft of my valuables or personal items.*

CHILDREN IN THE WAITING ROOM. ProScan is not responsible for providing supervision of any child during your imaging exam. You are welcome to bring your child or children if there is another adult accompanying you to supervise your child or children while your imaging exam is being done.

**I have read and understand the above statements and acknowledge that ProScan and its employees will not be responsible for providing childcare for my child or children during my imaging exam.*

CANCELLATION POLICY. If you will not be able to appear for your scheduled appointment, you must notify ProScan 24 hours prior to your appointment time. If you miss or cancel your appointment without giving the appropriate 24-hour notice, ProScan may charge you a $50.00 cancellation fee.

**I have read and understand the above statements and acknowledge that if I do not provide ProScan with 24 hours prior notice that I cannot keep my scheduled appointment, I may be charged a $50.00 cancellation fee.*

BY SIGNING THIS DOCUMENT BELOW, I HEREBY ACKNOWLEDGE THAT I HAVE BEEN OFFERED AND/OR HAVE RECEIVED A COPY OF PROSCAN IMAGING AND AFFILIATED ENTITIES NOTICE OF PRIVACY PRACTICES.

I hereby give my consent for ProScan Imaging and Affiliated Entities to release my protected health information to the following individual(s): *(PLEASE PRINT)*

________________________________ Relationship to Patient____________________

________________________________ Relationship to Patient____________________

________________________________ Relationship to Patient____________________

FOR PROSCAN IMAGING USE ONLY – RECEIPT OF NOTICE OF PRIVACY PRACTICES ONLY

Date Acknowledgment Received: ___________________________ Initials: _______________

-OR-

Reason Acknowledgment was not obtained: ____

____

____ Date: ___________________________

Patient or Legal Representative Signature

____ ____

Print Name Relationship/Authority if Legal Representative

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