Welcome to our Imaging Center

Patient Information

Last Name: ________________________________ First Name: ____________________________ MI: ______

Gender: ○ M ○ F Birth Date: _________________ Social Security #: __________________________

Home Address: ____ City: ___________________

State: _______ Zip: ______ Marital Status: ○ Single ○ Married ○ Minor ○ Other: _________________

Home Phone: __________________ Cell Phone: ___________________ Work Phone: _________________

(If patient is minor, give parent/guardian employment information)

Employer: ____ Occupation: ______________________________

Employer Address: _______________________________ City: ________________ State: _____ Zip: ______

Emergency Contact: ____________________________ Relationship: ______________ Phone: ___________

If patient is minor, give parent/guardian (s) name (s): ____

Name of person child currently lives with: __________________________ Relationship: ________________

Insurance Information

PRIMARY INSURANCE INFORMATION ○ Medicare ○ Medicaid ○ PPO ○ HMO ○ Private Pay

Insurance Company: ____ Phone: _____________________

Policy holder's name: ____

Policy Holder's SS # _________________________________ Relationship to insured: __________________

Date of Birth: _________________ Policy #: ______________________________ Grp#: _________________

SECONDARY INSURANCE INFORMATION ○ Medicare ○ Medicaid ○ PPO ○ HMO ○ Private Pay

Insurance Company: ____ Phone: _____________________

Policy holder's name: ____

Policy Holder's SS # _________________________________ Relationship to insured: __________________

Date of Birth: _________________ Policy #: ______________________________ Grp#: _________________

Please present your insurance cards and picture id to the office staff

I hereby certify that all information on this Patient Registration form is true and correct.

Patient or Parent/Guardian Signature: ______________________________ Date: ____________

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Benefits

Precertification # ___________________________ Referral # _________________________________

Your deductible is ______________ (Met / Not Met) Your patient % ________. Your Co-Pay ______

Insurance contract rates for CPT code(s)

_________ is $ _________
_________ is $ _________
_________ is $ _________
_________ is $ _________

ICD-9 Code (s)

_______ ________ _______ _______
_______ ________ _______ _______
_______ ________ _______ _______
_______ ________ _______ _______

The total amt for all CPT codes is $ __________

Based on this information your **estimated** cost is $_________. This is only an **estimate** of your responsibility /liability and cannot be confirmed by Round Rock Imaging until your medical claim is processed by your insurance company and we receive the insurance payment/EOB.

Amount paid at time of service $ _______________ Preferred method of payment:

Cash, Check, MC, Visa, Discover, Am Ex or HSA/FSA.

Patient or Parent/Guardian Signature: ______________________________________ Date: ______________________

Assignment of Benefits

I hereby authorize payment of all health insurance benefits to Round Rock Imaging, Ltd and allow assignee to release all information necessary to secure payment. I agree that a photocopy of this authorization shall be considered as effective and valid as the original. I understand that I am legally responsible for all charges incurred whether or not they are paid by said insurance and that any unpaid balance shall be due in full IMMEDIATELY, 45 days after my date of service. I will remit any payment made to me directly by my insurance carrier for services billed by Round Rock Imaging Ltd

I understand that I am financially responsible to Round Rock Imaging Ltd for charges not covered by this Assignment of Benefits.

I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to procedure.

Patient or Parent/Guardian Signature: ______________________________________ Date: ______________________

Release Information

I hereby authorize Round Rock imaging Ltd to furnish medical information concerning my present illness or injury to my family physician(s), referring physician(s), and insurance companies. I further authorize my family physician(s), referring physician(s), and other healthcare providers to furnish all medical information concerning my present illness or injury to Round Rock Imaging Ltd. .

I authorize the release of any necessary medical information to RRI, Ltd to assist in my diagnosis.

I have read, understood, and hereby consent to the MRI / CT / examination and the above conditions.

Patient or Parent/Guardian Signature: ____________________________ Date: ___________