PATIENT REGISTRATION FORM
Please Print Legibly

CIC _____

PATIENT

Today's Date	Referring Doctor	How did you hear about our Facility?	Race

Ethnicity

☐ American Indian or Alaskan Native ☐ Asian or Pacific Islander ☐ Black, not of Hispanic origin ☐ Hispanic ☐ White, not of Hispanic origin

Last Name	First Name	Middle Name

Street Address	Apt #	City	State	Zip Code

Home Phone Number	Cell Number	Sex	Date of Birth / /	Age	Marital Status	Social Security Number

Employer's Name or School	How Long Employed?	Phone Number

Employer's/School's Street Address	City	State	Zip Code

POLICY HOLDER (GUARANTOR)
(If same as patient, you may skip this section.)

Last Name	First Name	Middle Name	Relationship to Patient

Street Address	Apt #	City	State	Zip Code

Home Phone Number	Cell Number	Sex	Date of Birth / /	Age	Marital Status	Social Security Number

Employer's Name or School	How Long Employed?	Phone Number

Employer's/School's Street Address	City	State	Zip Code

INSURANCE INFORMATION
Please present all insurance cards to the receptionist.

Policyholder's Name	
Policyholder's Date of Birth	
Primary Insurance Carrier	Primary Insurance Member ID
Secondary Insurance Carrier	Secondary Insurance Member ID

EMERGENCY CONTACT

Last Name	First Name	Relationship to Patient

Street Address	Apt. #	City	State	Zip Code

Home Phone Number	Cell Number

Please complete the reverse side of this form.

AUTHORIZATION FOR REQUEST OF MEDICAL RECORDS

I hereby authorize my physicians to release information from my record verbally, via fax or mail to Clarksville Imaging Center including, but not limited to, diagnosis and test results as needed pertaining to the accurate performance and interpretation of my Imaging exam.

INITIAL _____

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Clarksville Imaging Center to release information from my medical record (including diagnosis and test results) to my referring physician and/or case worker.

I certify that information given by me is correct. I hereby authorize payments directly to Clarksville Imaging Center of the insurance benefits otherwise payable to me.

Clarksville Imaging Center is a filmless facility. I agree to give them a 24 hour notice if my physicians require a copy of my imaging study.

INITIAL _____

CONSENT TO TREATMENT AND TESTS

I have been referred for care (treatment, testing or otherwise) at Clarksville Imaging Center. I permit Clarksville Imaging Center and its employees, and others involved in my care to provide testing, services or care that is beneficial to me, under the orders or direction of my physician. I have the right to ask questions and receive information about my care and treatment, and the right to withdraw my consent.

I acknowledge and agree that NO Guarantees have been made to me as to the results or outcome of my treatment, testing and/or other care.

INITIAL _____

FINANCIAL RESPONSIBILITY & ASSIGNMENT OF INSURANCE BENEFITS

The undersigned jointly and severally agree, in consideration for the services rendered to the below named patient, accept financial responsibility and agree to pay the Imaging Center for its charges for services rendered to the patient. Even though insurance benefits have been assigned to provider, the undersigned clearly understands and agrees to pay the Provider's bills or the unpaid balance of the bill due. If this account should be placed in the hands of a collector or attorney for collection, fees (which shall equal one-third of any balance due), court cost and other expenses will be paid by the undersigned in addition to the bills. Notice of dishonor, demand and protest is waived.

As partial security for the services to be rendered to me, I do hereby unconditionally assign all payments of insurance benefits to which I may be entitled because of this period of medical treatment, up to and including Provider's regular and customary charges for services rendered to me. It is understood that this assignment includes all health insurance policies owned by me regardless of whether the policy contemplated direct payment to me or to the Provider and further covers all claims that I may have against any third party who was legally responsible for the injuries or illnesses which are the cause of this period of medical treatment.

I certify that the information given by me in applying for payment under Titles XVIII and XIX of the Social Security Act, or under other insurance coverage is correct. I request that payment of authorized benefits be made on my behalf to Clarksville Imaging Center. I transfer and assign to the Imaging Center and to other entities providing special services which may be covered by the third party payer, all of my rights to benefits payable to me or to the beneficiary under all applicable policies of insurance or health plan(s) listed with the facility at registration, and those not listed and which are later determined to provide coverage. By this assignment, I authorize payment directly to Clarksville Imaging Center. It is my responsibility to take the action necessary for such benefits to be paid to Clarksville Imaging Center. If a third party or its Insurer is liable to me for my injuries and expenses, including my Imaging Center charges, I authorize and direct such third party and insurer to withhold from any settlement or judgement which I may recover, such sums as are due and owing to the facility for services rendered to me, and such sums are hereby assigned to the Imaging Center and are to be paid directly to the Imaging Center by such third party or insurer. I understand that I am fully responsible for charges and this does not relieve me of my personal responsibility to pay the charges when due.

DATE_____ SIGNED_____

(Patient's Signature or Parent/Guardian's Signature)