For Partners Use

MRN #

PATIENT REGISTRATION SHEET

Patient Name : _____
LAST FIRST M

Date of Birth : _____ Social Security # : _____

Address : _____
STREET APT # CITY

_____ E-Mail Address : _____
STATE ZIP

Home Phone : ( ) _____ Cell Phone : ( ) _____

Work Phone : ( ) _____ ◯ Male ◯ Female

Language: ☐ English ☐ Spanish Other: _____

Ethnicity: ☐ Hispanic / Latino ☐ Non Hispanic / Latino

Race : ☐ White Caucasian ☐ African American ☐ Asian ☐ Native American ☐ Other

Insurance and co-pays : It is the policy of Partners Imaging Centers to collect any co-pays, deductibles or co-insurance at the time of service. The amount collected is normally regulated by your insurance provider. Payment for can be made by cash, debit or credit card. It is possible that your insurance provider may not cover the entire cost of the service provided. In this event, you are responsible for any balance outstanding. A statement will be sent to your home address. Any balances detailed on the statement are due immediately unless a payment arrangement has been made with our billing department.

Authorization for access by others to your Protected Health Information

Please check all situations below where you would grant individuals listed below access to your PHI :

Name : _____ Relationship : _____

☐ Confirmation of appointment details ☐ Pick up medical records ☐ Billing information

Name : _____ Relationship : _____

☐ Confirmation of appointment details ☐ Pick up medical records ☐ Billing information

Acknowledgment : By submitting this form, I hereby permit Partners Imaging Centers to disclose my PHI to the individual(s) indicated above. I understand each individual that I have listed will be required to provide a valid ID as proof that they are whom they claim to be, in order for my PIH to be released. I also understand that Partners Imaging Centers reserves the right to deny individuals listed access to my PIH records.

_____ _____

Patient / Parent / Guardian Signature **Date of Authorization**