# 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____ Armenian____

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 _____

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**Employer**: _____

**Occupation**: _____ Work Phone: (_____) _____

**Employer Address**: _____

**City/State/Zip Code**: _____

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**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: 11/2020

## 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: _____ 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: _____ Relationship to Patient: _____

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**ASSIGNMENT OF BENEFITS OTHER THAN MEDICARE:** I hereby assign and authorize payments for services rendered to be paid directly to Sacramento 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 Sacramento Imaging 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 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 Sacramento 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 Sacramento 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: 11/2020

# HIPAA Acknowledgment

***Patient Consent for Use/Disclosure of Protected Health Information***

*I understand that my/the patient's health information is private and confidential. I understand that Sacramento Imaging works hard to protect my/the patient's privacy and preserve the confidentiality of my/the patient's personal health information. I understand the Sacramento Imaging may use and disclose my/the patient's health information to provide treatment to me/the patient, to handle billing and payment, and to take care of other healthcare operations. In general, there will be no other uses and disclosures of this information unless I/ the patient permit it. I understand that sometimes the law may require the release of this information without my permission. These situations are very unusual, but one example would be if a patient threatened to hurt someone.*

*Sacramento Imaging has a detailed document called the "Notice of Privacy Practices". It contains more information about how we may use and disclose patient health information. I understand that I have a legal right to read the "Notice" before I sign this consent.*

*Sacramento Imaging may update the "Notice of Privacy Practices". If I ask, Sacramento Imaging must provide me with the most current "Notice".*

*Under the terms of this consent, I can ask Sacramento Imaging to restrict how my/the patient's protected health information is used or disclosed to carry out treatment, obtain payment, or other healthcare operations. I understand that Sacramento Imaging does not have to agree to my/the patient's request if it interferes with any of the above.*

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*I may cancel this consent at any time by writing, signing, and dating a letter to Sacramento Imaging. If I write a letter, it must specifically state that I want to revoke my/the patient's consent for authorization to use/disclose health information for treatment, payment, and other healthcare operations.*

*My signature below indicates that I have been given the option to read and review a current copy of Sacramento Imaging's If I revoke this consent or do not agree to sign this consent form, Sacramento Imaging does not have to provide any healthcare services to me/the patient. "Notice of Privacy Practices".*

*My signature means that I agree and consent to allow Sacramento Imaging to use/disclose my/the patient's protected health information to carry out treatment, obtain payment, and any other additional healthcare operations.*

Signature_____ Relationship to Patient_____

Relationship to Patient_____

Relationship to Patient_____

Sacramento IMAGING

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# Office Policies

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

***RESPONSIBILITY FOR VALUABLES.*** Sacramento Imaging 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 Sacramento Imaging and its employees are not liable for the loss or theft of my valuables or personal items.*

***CHILDREN IN THE WAITING ROOM.*** Sacramento Imaging 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 Sacramento Imaging 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 Sacramento Imaging 24 hours prior to your appointment time. If you miss or cancel your appointment without giving the appropriate 24-hour notice, Sacramento Imaging may charge you a $25.00 cancellation fee.

**I have read and understand the above statements and acknowledge that if I do not provide Sacramento Imaging with 24 hours prior notice that I cannot keep my scheduled appointment, I may be charged a $25.00 cancellation fee.*

**BY SIGNING THIS DOCUMENT BELOW, I HEREBY ACKNOWLEDGE THAT I CAN REQUEST A COPY OF SACRAMENTO IMAGING AND AFFILIATED ENTITIES NOTICE OF PRIVACY PRACTICES.**

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

Date Acknowledgment Received: _____ Initials: _____

**-OR-**

Reason Acknowledgment was not obtained: _____

_____

Date: _____