Bristol Radiology Center - Farmington Imaging Center

PATIENT REGISTRATION FORM

PLEASE PRINT

Name:_____ Sex: M__ F__

Social Security No __ __ __ __ __ __ __ __ __ Date Of Birth: _____

Street Address:_____

City:_____ State:_____ Zip:_____

Mailing Address (If Different)_____

Telephone: Home_____Work_____Cell_____

Employer Name:_____Occupation:_____

Employer Address:_____ City/St _____Retired/Date_____

What Physician ordered today's exam? _____

Would You Like Your Report Sent To Any Other Physician(s)? _____

Spouse / Guardian Name: _____

Spouse / Guardian Employer _____Phone:_____

INSURANCE INFORMATION

Please Present Your Insurance Cards At Registration

Primary Insurance: _____

Subscriber's Name (If Different From Patient): _____

Last 4 Numbers of your Social Security __ __ __ __Date of Birth: _____

ID # :_____Group# _____

Secondary Insurance: _____

Subscriber's Name (If Different From Patient): _____

ID # _____Group# _____

Is This a Workers' Compensation Claim? Yes___ No___ If Yes, Claim Number:_____

Is This a Motor Vehicle Claim? Yes___ No____ If Yes, Claim Number:_____

Your insurance is filed as a courtesy to you. All services not paid within 30 days by your insurance company will become your responsibility.

1. All copays, deductibles, co-insurance, previous balances, and fees for non-covered services are due at the time of your visit. You will be responsible for all collection fees associated with the collection of your account.
2. If you are a Medicare recipient, we will file your Medicare as required for participation in the Medicare program. If your Medicare is primary, please notify Medicare of your supplemental insurance. Medicare normally forwards claims to a supplement for processing of co-insurance or deductibles. This does not guarantee your supplement will pay these balances.
3. Services we provide to you may or may not be covered by your insurance due to routine, non-covered, or "deemed medically unnecessary" by your insurance company. In the event your insurance company does not cover your services, you will be responsible. We will make every effort to let you know if we feel your insurance company may not cover your services. You are responsible for knowing the benefits/coverage of your insurance.

CONSENT FOR TREATMENT AND RELEASE OF INFORMATION

I AUTHORIZE Bristol Radiology Center/Radiologic Associates, PC ("BRC/RAPC") to perform medical treatment.

I CONSENT to BRC/RAPC's use and disclosure of all individually identifiable personal, health, financial, and demographic information (known as Protected Health Information or PHI) for the purposes of:

- Providing medical treatment
- Obtaining payment and reimbursement
- Obtaining authorizations from my insurance for tests (where required)
- Requesting healthcare services from other providers
- Cooperating with other providers in my medical treatment
- Fulfilling requests for information when specifically authorized by me
- In addition, doing all other things directly related to providing healthcare to me

The above purposes and all other uses are known collectively as Treatment, Payment, and Other healthcare operations or TPO.

I AUTHORIZE any physician or healthcare facility to provide upon request any PHI to BRC/RAPC, when needed for the purposes of TPO.

I CONSENT to BRC/RAPC discussing any or all of my medical care including my evaluation, treatment, diagnosis even if related to psychiatric or psychosocial impairments, substance abuse, acquired immunodeficiency virus (HIV), HIV-related opportunistic infections, or pregnancy with the following person(s).

1._____Relationship:_____

2._____Relationship:_____

3._____Relationship:_____

The Health Insurance Portability and Accountability Act of 1996 prohibits the use and disclosure of protective health information for treatment, payment, and other healthcare operations without a signed consent and prohibits the use and disclosure of protective health information for non healthcare related activities without specific and explicit authorization.

Exam(s) requested on behalf of _____DOB _____

are needed for comparison reasons.

Please send: _____**exam & report**

_____**exam & report**

To: Bristol Radiology Center

25 Collins Rd.

Bristol,CT 06010

PATIENT'S SIGNATURE:_____DATE:_____

GUARDIAN'S SIGNATURE:_____DATE:_____

(signatures will stay on file for 1 year)