



PALMS IMAGING C E N T E R

Setting the standard for service, commitment & accuracy.

Registration Form

(If the patient is under the age of 18, parent/guardian **must** complete)

Last Name _____ First Name _____
Date of Birth ___ / ___ / ___ Sex _____
Address _____ apt: _____
City _____ State _____ Zip Code _____
Home Phone _____ SSN _____

Insurance Subscriber Information (if other than yourself)

Name _____ Date of Birth _____ Sex _____
Address _____ City _____
State _____ Zip Code _____
Home Phone _____ SSN _____
Relation to Patient _____

Emergency Contact

Name _____ Relationship _____
Home Phone _____ Alternate # _____

Insurance Liability

Palms Imaging Center bills all insurance carriers as a courtesy. However, payment for all services rendered is ultimately the patient's responsibility.

Primary Carrier _____ ID# _____
Secondary Carrier _____ ID # _____
Third Carrier _____ ID# _____

It is understood and agreed that I the patient and/or responsible party (if minor) acknowledge and accept full responsibility for the charges for services rendered at Palms Imaging Center. I also authorize the release of any medical information necessary to process this claim. I authorize payment of medical benefits to the undersigned physician or supplier of services rendered. I am responsible for all co-pays, deductibles, non-covered services, and denied claims including, but not limited to, medical necessity.

Patient/Guardian Signature _____ Date _____