PALMS IMAGING CENTER

Setting the standard for service, commitment & accuracy.

Registration Form

(The patient must complete. 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: _____

Primary Contact Number: _____ SSN: ____-___- ____

Insurance Subscriber Information (If other than yourself)

Name: _____ Date of Birth: ____ /____ /____ Sex: _____

Address: _____ Apt: _____

City: _____ State: _____ Zip Code: _____

Home Phone Number: _____ SSN: ____-____-____

Relation to Patient: _____

Emergency Contact

Name: _____ Relationship: _____

Primary Contact Number: _____

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.

Patients Name Printed: _____ Date: _____

Patients Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

1901 Outlet Center Dr. Suite 120 • Oxnard CA 93036 • Telephone: 805.604.9500 • Fax: 805.604.9559
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Acknowledgment of Receipt of Palms Imaging Center Privacy Practices Notices

I, _____ have received a copy of Palms Imaging Center Privacy Notices.

Patients Name Printed: _____ Date: _____

Patients Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

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Release of Medical or Financial Information

Please list below any persons for whom you will allow us to release any medical or financial information to. If no one is listed, Palms Imaging will only discuss your medical or financial information with you. Information will still be provided to other health care providers, hospitals, or your insurance companies for the purpose of authorizations or other treatment or specialty referrals. Information to any other entity will need your separate signatures specifically authorizing them access to your records.

I hereby authorize each of my physicians and other health care professionals (together "Providers") to disclose my medical records and health insurance information, including but not limited to information related to my medical condition and treatment, my health insurance coverage, my name, address, telephone number, Social Security number, and insurance number (together, "Protected Health Information") to the following individuals/entities and its agents and representatives for the purposes described below:

Name	**Relationship**
_____	_____
_____	_____

(If you have any additional individuals/entities please list them on back of this notice.)

Specifically, I authorize the individuals/entities listed above to receive, use, and disclose my Protected Health Information in order to _____

_____.

I understand that once my Protected Health Information has been disclosed to the individuals/ entities I have listed, federal privacy laws may no longer protect the information and that my Protected Health Information may be subject to re-disclosure.

I understand that I am not required to sign this Authorization. If I do not sign, my treatment, payment for treatment, insurance enrollment, or eligibility for insurance benefits, will not be directly affected. I understand that I may cancel (revoke) this Authorization to my Providers.

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Once my Providers receive and process the notice of cancellation (revocation) of this Authorization, my Providers may no longer make disclosures of my Protected Health Information to the individuals/entities I have listed. However, this Authorization will not affect the individual/ entity's ability to use and disclose Protected Health Information that it has already received (unless the laws of my state prevent the individual/entity from continuing to use and disclose such Protected Health Information). I understand that my right to cancel (revoke) this Authorization is limited to the extent that my Providers have previously taken action in reliance on this Authorization. This Authorization expires on _____. I understand that I have a right to receive a copy of this Authorization.

Patient/Personal Representative: _____

Relationship (if signed by personal representative): _____

Signature: _____

Date: _____

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