



MRN #

PATIENT REGISTRATION SHEET

Patient Name : LAST FIRST M

Date of Birth : Social Security # :

Address : NO # / APT # STREET CITY

STATE ZIP Male Female

Home Phone : ( )

Work Phone : ( ) E-Mail Address :

Cell Phone : ( )

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 (PHI)

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

Name 1 : Relationship :

Confirmation of appointment details Pick up medical records Billing information

Name 2 : 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 PHI to be released. I also understand that Partners Imaging Centers reserves the right to deny individuals listed access to my PHI records.

Patient / Parent / Guardian Signature

Date of Authorization