Anaheim Hills Imaging Center

Service Date	PT ID#
CPT, Exam Description	

Patient Information

Last Name	First Name	MI	Date of Birth	Sex

Address	City	State	Zip Code

Home Phone#	Work #	Cell#	Patient's Email

Patient's Employer	Employer Address	City	State	Zip Code

Emergency Contact	Relation to patient	Emer. Contact Phone#	

Referring Physician	Referring Physician Phone #	Ref Physician Fax #

Ref Physician Address	City	State	Zip Code

Responsible Party (please write "same as above", if applicable)

Last Name	First Name	MI	Date of Birth	Sex

Address	City	State	Zip Code

Relation to patient	Phone#	Email	Employer

Insurance / Payor

Insurance / Payor	Policy Number	Group Number	

Subscriber First Name	Subscriber Last Name	Date of Birth	Relation to patient

Is there any possibility you are pregnant? **YES** **NO** **Patient's initials: _____**

Are you currently involved in a clinical trial study? **YES** **NO** **Patient's initials: _____**

I agree that all of the above information is true and correct.

Signature: _____

Parent or Legal Guardian Signature: _____

FOR OFFICE USE ONLY:
Patient name, date of birth, exam & physician have been verified. Please initial below:

Front Office: _____

Tech(s): _____

PATIENT CONSENTS:
Please initial each consent section

PT ID#

_____ **Consent to Procedure:** The undersigned patient/ responsible party consents to the imaging procedure(s) listed above ordered by my physician.

_____ **Financial Responsibility**: By accepting any medical service or treatment, including but not limited to the above listed procedure(s), the undersigned patient/responsible party agrees to pay all charges for such service or treatment. Your insurance is filed as a courtesy to you. All co-pays, deductibles, co-insurance, previous balances, and fees for non-covered services are due at the time of your visit. We will provide you with a statement of your account, when requested, to bill to a secondary or tertiary insurance, once your account is paid in full. We will bill secondary insurances, when needed, if required by a specific contract. If you are a Medicare recipient, we will bill your claim to Medicare as required for participation in the Medicare program. We will provide the best possible care for you. 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 a third party payor does not cover payment of your services, you will be responsible. We will make every effort to let you know if we suspect your insurance company may not cover your services. You are responsible for knowing the benefits/coverage of your insurance.

_____ **Release of Information**: I agree that to the extent necessary to determine liability for payment and to obtain reimbursement, the provider may disclose portions of my medical record to any person or corporation which is or may be liable for all or any portions of the provider's charges, including but not limited to insurance companies, health care service plans or workers' compensation carriers. I understand that medical information may also be released to review organizations and, if necessary, any agencies that may be involved in continuing patient care. I agree and acknowledge that this authorization and consent continue until such time as written notice revoking said consent from the patient or the patient's legal representative is received by the provider.

_____ **Notice of Privacy Practices (NPP) Acknowledgement:** A Notice of Privacy Practices (NPP) is provided to all patients. This NPP identifies: 1) How medical information may be used or disclosed; 2) your rights to access your medical information, amend your medical information, request an accounting of disclosures of your medical information, and request additional restrictions on our use and disclosures of that information; 3) Your rights to complain if you believe your privacy rights have been violated; and 4) Our responsibilities for maintaining your privacy as your medical representative. **I have been offered and have read a copy of the facility's Notice of Privacy Practices.**

_____ **Consent to Contact**: By providing a telephone number, I expressly consent and authorize the facility, any practitioner or clinical provider as well as any of their related entities, agents, or contractors, including but not limited to schedulers, marketers, advertisers, debt collectors, and other contracted staff (collectively referred to herein as "Provider") to contact me through the use of any dialing equipment (including a dialer, automatic telephone dialing system, and/or interactive voice recognition system) and/or artificial or prerecorded voice or message. I expressly agree that such automated calls may be made to any telephone number (including numbers assigned to any cellular or other service for which I may be charged for the call) used by, or associated with me and obtained through any source including, but not limited to, any number I am providing today, have provided previously or may provide in the future in connection with the medical goods and services and/or my account. By providing a telephone number, I expressly consent to the receipt of text messages from Provider at any telephone number (including numbers assigned to any cellular or other service for which I may be charged for the call) used by, or associated with, me and obtained through any source including, but not limited to, any number I have provided previously or may provide in the future in connection with my account. By providing this express consent, I specifically waive any claim I may have for the making of such calls, including any claim under federal or state law and specifically any claim under the Telephone Consumer Protection Act, 47 U.S.C. § 227. By providing a telephone number, I represent I am the subscriber or owner or have the authority to use and provide consent to call the number.
By providing my email address now or at any time in the future in connection with the medical goods and services provided and/or my account, I expressly opt-in to the receipt of email communications from Provider for or related to the medical goods or services provided, my account, and other services such as financial, clinical and educational information including exchange news, changes to health care law, health care coverage, care follow up, and other healthcare opportunities, goods and services. By providing this express consent, I specifically waive any claim I may have for the sending of such emails, including any claim under federal or state law and specifically any claim under the CAN-SPAM Act, 15 U.S.C.§ 7701, et seq. By providing an email address, I represent I am the subscriber or owner or have the authority to use and provide consent to contact the email address.

I understand that providing a phone number and/or email address is not a condition of receiving medical services. I also understand that I may revoke my consent to contact at any time by directly contacting Provider or utilizing the opt–out method that will be identified in the applicable communication.

Printed Name: _____

Signature: _____ Date_____

Parent or Legal Guardian Signature: _____