Phone (205) 823-0882

Fax (205) 823-0872

(Please print)

Shades Mountain Imaging™

OUTPATIENT REGISTRATION FORM

Date: _____

Patient Name: _____ Date of Birth: _____ Sex: _____

Patient Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (____) _____ Work: (____) _____ Cell: (____) _____

Name of Refferring Physician: _____

Patient's Employer: _____ Occupation: _____

Patient's Social Security No: _____ Race: _____ Smoker: Yes or No

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Contract Holder, if Other Than Patient: _____ Date of Birth: _____

Relationship to Patient: _____ Employer: _____

Please present photo identification card and insurance card(s). ✓ Check the following:

Blue Cross ☐ Medicare ☐ Medicaid ☐ Other ☐ _____

Assignment of Benefits: The undersigned assigns to and authorizes the benefits payable for radiological (x-ray) services to Shades Mountain Imaging, P.C.

Authorization to assign Benefits and Release Information to Medicare / Medicaid:
I certify the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and Centers for Medicare and Medicaid Services or its intermediaries any information needed for this or other related Medicare claims. I request the payment of authorized benefits be made on my behalf to Shades Mountain Imaging, P.C.

Financial Responsibility:
The undersigned is agreeable and understands that Shades Mountain Imaging, P.C. charges that are not paid may be placed with a collection agency and that I will be responsible for the payment of the amount due including any collection fees and attorney fees.

(Continued on reverse side)

(Cont.)

I understand that my insurance company may consider the procedure(s) to be a non-covered service(s) and may not pay for this procedure. Therefore, I agree to assume the financial responsibility for this medical care and to pay the full charge of the services.

Patient Consent Agreement:
I understand that as a part of my healthcare, Shades Mountain Imaging, P.C. originates and maintains health records describing my health history, symptoms, examination, test results, diagnosis, treatment, and plans for future care or treatment. I understand this information serves as basis for my treatment and diagnosis, a means of communication among other health professionals who contribute to my care, and a source of information for payment requirements for medical insurance companies. I authorize Shades Mountain Imaging, P.C. to release medical or other personal information orally, written or electronically which may be necessary for the completion of insurance forms, payment for services, further treatment or receipt of benefits.

I have been provided with a copy of Shades Mountain Imaging's **Notice of Privacy Practices** concerning how the use and disclosure of my Protected Health Information will be handled by this practice.

Signature _____ Date _____
(Patient or Responsible Party)