Premier MRI 4U
PATIENT REGISTRATION FORM

Patient Name:____ SS # ___________________________________

Address: ____ City ______________ ST___ Zip ___________

Sex: M F Date of Birth ____________________________ Age ________ S____ M____ D____ W____

Employer Name & address ____

Work # ___________________ Home # __________________ Cell # __________________ Other # ___________________

Email address: __________________________ Name of School: ________________ Student: Full time Part time

Emergency Contact Name: __________________________________ Phone# ______________________________

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*If you are not **responsible for today's payment**, then this section needs to be **completed in full with the responsible party information.** Please give your insurance card and driver license to the Front Desk Receptionist.*

Your relationship to responsible party: Self Spouse Dependent

Responsible Party Name: _______________________________ Date of Birth: _____________ Male Female

Address: ____ City________________ ST___ Zip __________

Work #: __________________ Home # __________________ Cell # ___________________ Other # _________________

Please read carefully and let us know if you have any questions, then sign below:

I hereby assign, transfer, and set over to Fairway Imaging LLC, (dba) PREMIER MRI4U all of my rights, title and interest to my medical benefits and reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking this authorization. **I understand that I am financially responsible for all charges** whether or not they are covered by insurance. I also the provider to use this signature on all of my insurance submissions and a copy is also valid as the original. I request that payment may be made to this provider on any and all services furnished to me. I understand that if other health insurance is indicated, my signature authorizes releasing to the same information to the agency or insurance shown. In Medicare assigned cases, the provider agrees to accept the assignment shown and agrees to determination. I will then be only liable for any deductible, co pays, or coinsurance indicated by my carrier. I have been given the opportunity to read the office financial policy and understand my rights.

I have read the above, and hereby give permission to Premier MRI4U to obtain any previous reports and/or films from prior studies or previous operations related to the area of the body which is being scanned today. I further authorize Premier MRI4U to release the results of all my tests to my referring physician and insurance carrier via films, hardcopy medical report and/or facsimile.

I have also been given a Notice of Privacy Practices, Patient Bill of Rights and Customer Care Responsibility forms. I understand that the below consent is an authorization in order for my provider to obtain health care benefits treatment, payment, enrollment, or eligibility, as described in the notice. I understand that I may revoke this in writing and it would not affect any actions already taken by this provided based upon this authorization or consent. I understand that once this office discloses my health information the persons or entity that receives it may re-disclose it. The HIPPA Privacy may no longer protect it. I certify that I am the patient or am authorized by the patient as the general agent to execute and accept all above and below and accept its terms.

Patient Signature _______________________________ Witness __________________________ Date __________________

Responsible Party _______________________________ Relationship to Patient ____________________________________