MRN # ____________________

PATIENT REGISTRATION

Last Name ______________________ **First** Name ______________________ Middle ________

Mailing Address / PO BOX / APT# / UNIT# ____

City ______________________ State ____________ Zip ____________

Date of Birth ______________ ☐ Female ☐ Male Social Security # ________________

CELL Phone ______________________ **HOME Phone** ______________________

Employer or School ______________________________ **WORK Phone** ______________

Driver's License(State & #)______________ Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Email Address __________________________________

EMERGENCY Contact Name / Phone # / Relationship ______________________________

PLEASE ANSWER / CIRCLE LINES 1 - 5

1. Today's exam date ______________________

2. Is today's exam related to a WORK INJURY? (Work Comp)		**YES**	**NO**
3. Is today's exam related to a PERSONAL INJURY CASE?		**YES**	**NO**
4. Is today's exam related to a:	**Motor Vehicle Accident**	**YES**	**NO**
	Slip and Fall	**YES**	**NO**

5. Date of Injury ______________________ **State where accident / injury occurred** ____________

Other / Notes ____

→ **PRIMARY Insurance Company** ____________________________________

Primary policy holder ______________________ His/Her Date of Birth ______________

Relationship to primary policy holder ☐ Self ☐ Spouse ☐ Child ☐ Other ______________

→ **SECONDARY Insurance Company** ____________________________________

Secondary policy holder ______________________ His/Her Date of Birth ______________

Relationship to secondary policy holder ☐ Self ☐ Spouse ☐ Child ☐ Other______________

PLEASE TURN THIS PAGE OVER →

MRN # ___________________

AUTHORIZATIONS

AUTHORIZATION OF RELEASE OF MEDICAL RECORDS AND CD / FILMS: I hereby authorize Carlsbad Imaging Center / Imperial Radiology to release my medical records, diagnostic reports, or CD/images to my referring physician(s). I understand that this authorization shall become effective immediately and shall remain in effect until I revoke it, in writing. I also agree to pay the fee of $15 associated with copying of a second CD of images.

ASSIGNMENTS OF BENEFITS: I authorize and direct my insurance carrier to pay directly to this provider of medical services any benefits due to me under my insurance plan. I also hereby authorize this provider to use and disclose any of my personal medical information for treatments / diagnosis and payment (including to my insurance company). I agree to pay the balance of charges not paid under my plan. I understand that a $5 late fee will be added to each additional statement generated for the balance that remains unpaid after 30 days from the initial statement date. I am aware that if my account is not paid in full 90 days from the date of the service **a 30% additional fee will be added to the balance, it will be sent directly to a collection agency and reported to a national credit bureau.** Returned checks will also be charged a $25 fee. Should the account be referred to an attorney for collection, the undersigned shall pay attorney's fees and other collection expenses. IF I AM UNINSURED, I am fully responsible for all charges.

CONSENT FOR MEDICAL TREATMENT / DIAGNOSIS: I authorize the Imaging Center to furnish the necessary medical treatment, or procedures, including diagnostic x-ray, local anesthesia, drugs, and supplies as may be ordered by the attending physician(s), his/her assistances or designees. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatment or diagnostic procedure conducted in the Imaging Center.

LIFETIME MEDICARE PART B AUTHORIZATION: If I have a Medicare Part B policy, I authorize any holder of medical or other information about me to be released to the Social Security Administration and Centers for Medicare & Medicaid Services or its intermediaries or carries, or to the billing agent of the Imaging Center any information needed for this or related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical benefits be made to the holder of this assignments on my behalf. I understand that I am responsible for any deductibles and coinsurances.

HIPAA: In accordance with city, state, and federal laws and regulations, including the Health Insurance Portability and Accountability Act of 1996 **(HIPAA), Carlsbad Imaging Center / Imperial Radiology** will protect patient records and other information that may reveal a patient's identity when using or disclosing such information for purposes of treatment, payment, and health care operations. I am aware that I can request to review the policy of **Carlsbad Imaging Center / Imperial Radiology** for patient's privacy.

IF THE PATIENT IS UNDER 18: I, ______________________________
(Printed Name of Parent / Legal Guardian)

am the parent / legal guardian of ______________________________
(Printed Name of Patient under 18)

I have read and understand the above written material in regards to the exam(s) for today's date of service.

Patient / Legal Guardian PRINTED name ______________________________

Patient / Legal Guardian Signature ______________________________ Date ____________

NOTIFICATION REGARDING FINANCIAL RESPONSIBILITY FOR MEDICAL SERVICES

1. I understand and acknowledge that my Insurers will only pay for services that they determine to meet their coverage requirements and benefit terms.

2. As examples: some insurers require prior authorization for certain services. Some insurers have decision-makers that disagree with the medical necessity of certain recommended treatments, tests or examinations.

3. If my Insurer determines that the services or any part of them are not medically necessary, or fail to meet other coverage requirements (such as obtaining authorization or filing a claim in a limited time), the Insurer may deny payment for that service.

4. I agree that if my Insurer denies all or any part of the Provider's charges for any reason, or if I'm not eligible at the time of service, I will be personally and fully responsible for payment of Provider's charges. Should my account be referred to an attorney or collection agency, I agree to pay actual attorney fees and collection expenses. All delinquent accounts shall bear interest at twelve percent per annum, not to exceed the maximum amount permitted by law.

5. Deductions and Copays cannot always be predicted at the time of service, as patients' benefits can change throughout the year. It is the responsibility of the patient/payee to communicate directly with their insurance carrier to determine the final cost of the service.

6. The undersigned certifies that he/she has read and understands the information above, and is the patient, or the person financially responsible for the patient's treatment needs, and is duly authorized to sign this document.

Name: ______________________________ Date: __________________

Signature: ____________________________

Carlsbad Imaging Center
6010 Hidden Valley Rd #125
Carlsbad, CA 92011
Ph. (760) 730-3536 Fax (760) 720-4833

Imperial Radiology
2407 Marshall Ave., Ste. A
Imperial, CA 92251
Ph. (760) 545-0340 Fax (760) 545-0341

DEXA (Bone Densitometry Exam)

FIRST NAME: ______________________ LAST NAME: ______________________

DOB: ___/___/___ HEIGHT(IN): _______ WEIGHT(LBS): _______

GENDER: FEMALE ___ MALE ___

HISTORY OF NONTRAUMATIC FRACTURES:

FEMUR: YES__NO__
HUMERUS: YES__NO__
SPINE: YES__NO__
FOREARM: YES__NO__
PELVIS: YES__NO__
Hip: YES__NO__

INDICATIONS: (mark the ones that apply)

HYPERTHYROID___
LOW BODY WEIGHT___
HEIGHT LOSS___
TOBACCO USER___
HYPOTHYROID___
ALCOHOLISM___
RENAL DISEASE___
CORTICOSTEROID___
FAMILY HISTORY OF FRACTURE___
CAUCASIAN___
EARLY MENOPAUSE___
AMENORRHEA___
OSTEOPOROTIC___
BILATERAL OVARIAN RESECTION___

WHAT MEDICATION(S) DO YOU TAKE FOR OSTEOPENIA / OSTEOPOROSIS, OR FOR YOUR "BONES"? ____

DOSAGE: _________ HOW LONG_________

MARK All THAT APPLY TO YOU:

BISHOSPHONATE__CALCITONIN__CALCIUM__ ACTONEL__
FLOURIDE__PTH 1-34__ THIAZIDE__VITAMIN D__ FOSAMAX__

IF FEMALE PLEASE INDICATE IF: PREMENOPAUSAL___ POSTMENOPAUSAL___

ARE YOU PREGNANT? : YES__ NO__