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.

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

Patient PRINTED name _____

Patient (or Legal Guardian) Signature_____ Date _____

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

am the parent or legal guardian of _____
(Printed Name of Patient under 18)

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_____

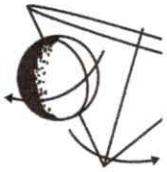
MARK All THAT APPLY TO YOU:

BISHOSPHONATE_____ CALCITONIN_____ CALCIUM_____ ACTONEL_____
FLOURIDE_____ PTH 1-34_____ THIAZIDE_____ VITAMIN D_____ FOSAMAX_____

IF FEMALE PLEASE INDICATE IF: PREMENOPAUSAL_____ POSTMENOPAUSAL_____

ARE YOU PREGNANT? YES_____ NO_____

CARLSBAD IMAGING CENTER
6010 HIDDEN VALLEY RD. #125
CARLSBAD, CA 92011
PHONE: (760)730-3536 FAX: (760)720-4833
WWW.CARLSBADIMAGING.COM



IMPERIAL RADIOLOGY
2407 MARSHALL AVENUE, SUITE A
IMPERIAL, CA 92251
PHONE: (760)545-0340 FAX: (760)545-0341
WWW.IMPERIALCOUNTYRADIOLOGY.COM

AGREEMENT REGARDING FINANCIAL RESPONSIBILITY FOR MEDICAL SERVICES

1. I understand that it is my responsibility to provide the most updated and accurate information concerning my insurance or health plan coverage to Carlsbad Imaging and/or Imperial Radiology ("Provider"). I understand that my health plan or health insurance company may specify co-payment amounts (copays") or Member Cost Share amounts for which I am responsible for paying directly to Provider.

2. I understand and acknowledge that my health insurers or health plan may pay only for services that they determine to meet their coverage requirements and benefit terms. For example: 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. I understand that if my insurer or health plan 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 or health plan may deny payment for that service.

4. Except as provided in Paragraph 5 below, I agree that I am responsible for Provider's charges (a) if not paid by the insurer or health plan, or (b) I am not eligible under my insurance or health plan at the time of service. I understand and agree that if my account is referred to an attorney or collection agency, I will also be responsible for paying the attorneys' fees, interest, and other costs of collection. All delinquent accounts shall bear interest at twelve percent per annum, not to exceed the maximum amount permitted by law.

5. In certain cases, Provider has agreements with health plans and insurers that prohibit Provider from seeking payment from their insured members for covered medical services, (other than copays or Member Cost Share amounts). In those situations, Carlsbad Imaging and Imperial Radiology will NOT seek payments from patients (other than copays or Member Cost Share amounts) for covered medical services. However, if I am notified by Provider that a service is not a covered service and I continue to request that Provider nonetheless deliver the non-covered service, I will be responsible for the cost of the service, regardless of the health plan or health insurance provisions.

6. 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 pay the correct copay or Member Cost Share amount either at the time of service, or as subsequently billed.

7. 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: _____