

# Affordable Medical Imaging Patient Registration Form

## PATIENT INFORMATION:

Patient's Name: \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Height (in): \_\_\_\_\_ Weight (lbs): \_\_\_\_\_ Gender: Male Female  
Last First MI  
(MM/DD/YYYY) (circle gender)

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Email: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

## EMERGENCY CONTACT INFORMATION: HOW DID YOU HEAR ABOUT US? (Please circle your response)

Name: \_\_\_\_\_ Internet Newspaper Sign  
Relation: \_\_\_\_\_ Phone book Friend/Co-worker TV  
Phone: \_\_\_\_\_ Mailing Referring Physician  
Radio Other \_\_\_\_\_

## PHYSICIAN INFORMATION:

Referring Physician: \_\_\_\_\_

Clinic: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Primary Physician: \_\_\_\_\_

Clinic: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

## INSURANCE INFORMATION:

Provider: \_\_\_\_\_

Policy Number: \_\_\_\_\_

## HIPAA PRIVACY PRACTICE NOTICE

Affordable Medical Imaging, LLC is required by law to maintain the privacy of, and provide individuals with, a notice of our legal duties and privacy practices with respect to protected health information. I have been informed by Affordable Medical Imaging, LLC of the Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. By signing my name below, I acknowledge that I have received this Notice of Privacy Practices for review and I understand and agree to its terms.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Staff Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## Payment Authorization Form

We appreciate you selecting Affordable Medical Imaging, LLC for your imaging exam. We will do everything we can to make your experience as comfortable and pleasant as possible. Please let us know if there is anything we can do to better serve your needs.

In order to achieve the goal of providing the best possible service to you at the lowest possible cost, full payment is due when services are rendered. We accept Visa, MasterCard, Discover, American Express and Debit Cards. We do not accept checks. The cost for a single MRI exam of any kind is \$395.00 plus \$50.00 for contrast. The cost for CT is \$350.00 plus \$75.00 for contrast. The cost for a single ultrasound exam of any kind is \$250.00. The cost for an Echocardiogram is \$295.00. The cost for a Vascular Screening is \$100.00.

If you intend to submit your paid receipt for reimbursement from your insurance company, you may need to contact your insurance company prior to having your exam.

Affordable Medical Imaging has partnered up with CareCredit to help with financial assistance. CareCredit application must be approved to use it same day. Please ask an associate for further details.

I, \_\_\_\_\_ hereby authorize Affordable Medical Imaging, LLC to charge a total of \$ \_\_\_\_\_ to my credit card or debit card for services rendered.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### OFFICE USE ONLY:

Name on Card: \_\_\_\_\_

Card Number: \_\_\_\_\_

Exp Date: \_\_\_\_\_ Card Security Code: \_\_\_\_\_

Card Zip Code: \_\_\_\_\_