

Chesapeake Regional Imaging	Exam Date and Time:	MRN/Jacket:	Patient Registration
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Name: \_\_\_\_\_  
 Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_  
 Email: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Race: \_\_\_\_\_ Gender: \_\_\_\_\_ Marital Status: \_\_\_\_\_  
 SSN: \_\_\_\_\_  
 Referring Physician: \_\_\_\_\_

**Emergency Contact Information**

Name: \_\_\_\_\_ Contact Phone: \_\_\_\_\_

**Insurance**

Primary Insurance Plan Name: \_\_\_\_\_  
 Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_  
 Secondary Insurance Plan Name: \_\_\_\_\_  
 Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

**Relationship to Insured**

Insured Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
 Insured DOB: \_\_\_\_\_

**Auto Accident or Worker's Compensation Information**

Is this injury due to accident?    Yes     No     If yes, what type of Accident? \_\_\_\_\_  
 Accident Date: \_\_\_\_\_    Accident State: \_\_\_\_\_

**Patient Name:**

**MRN/Jacket #:**

*By signing below, I agree to the following for outpatient radiology care provided by Chesapeake Regional Imaging*

## Authorization for Treatment

I hereby consent to and permit the attending physician and other medical staff to provide me treatment and care as may be deemed necessary and available to me during my office visit or outpatient procedure, including but not limited to tests, examinations, local anesthetics, x-rays and medical and surgical treatments, and other necessary procedures.

## Release of Medical Information

With this consent, Chesapeake Regional Imaging may use and disclose my protected health information for treatment, payment and health care operations as explained in the Chesapeake Regional Imaging. Notice of Privacy Practices. I also authorize release of my protected health information to Chesapeake Regional Imaging, the interpreting Radiologist group, government agencies (such as Medicare and Medicaid), insurance carriers, and other providers for treatment purposes. I understand that I may authorize a personal representative to have access to my protected health information as well.

**Would you like to authorize a personal representative to have access to your protected health information including your images, films and reports, please list the person's name, DOB and relationship?**

Yes  No

**MEDICAL RECORDS CAN BE RELEASED TO:**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

## Financial Responsibility

With this consent, I authorize Chesapeake Regional Imaging and/or their representatives to review my insurance coverage with my insurance company. I request that payment of authorized benefits be made directly to Chesapeake Regional Imaging on my behalf. I fully understand that I am financially responsible for any and all amounts not otherwise paid by my insurance carrier or worker's compensation. I also certify the information, on this form, given by me for payment under Title XVIII (Medicare) is correct and complete.

## Notice of Privacy Practices

I acknowledge that I had the opportunity to review the Notice of Privacy Practices. I understand I may request a paper or electronic copy of this policy to keep.

With this consent, Chesapeake Regional Imaging may call or email my home or other alternative location and leave messages or voice mail in reference to any items that assist them in carrying out treatment, payment and health care operations, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including test results, among others.

I understand I may revoke my consent in writing except to the extent that Chesapeake Regional Imaging has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it Chesapeake Regional Imaging may decline to provide treatment to me.

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Printed Name:** \_\_\_\_\_