MedCross Imaging LLC

PATIENT REGISTRATION

Patient Name: _____ DOB: _____ Soc Sec No:_____/___/_____

Sex: □ Male □ Female Marital Status: □ Single □ Married □ Separated □ Widowed

Address: _____City: _____ State: ___ Zip: _____

Home Number: (___) _____ - _____ Cell Number: (___) _____ - _____ E-mail: _____

Emergency Contact: Name: _____ Phone Number: (___) _____ - _____

Responsible Party (if other than patient):

Name: _____ DOB: _____Soc Sec No.:_____/___ /_____

Address: _____City: _____ State: ___ Zip: _____

Home Number: (___) _____ - _____ Cell Number: (___) _____ - _____Email :_____

Employer Name: _____Employer Address: _____City: _____ St: ___ Zip:____

Insurance Information (policy holder information):

Primary Insurance: _____ID No.: _____ Grp No: _____

Insured's Name: _____ Insured's DOB: _____Insured's SSN:_____

Secondary Insurance: _____ID No.: _____ Grp No: _____

Insured's Name: _____ Insured's DOB: _____Insured's SSN:_____

Is this exam accident related? If so, please fill out the section below:

Date of accident: _____ How did it happen?: □ Auto □ Work □ Other

Attorney's Name: _____ Phone (___) _____-_____

Address: _____City: _____ State: ___ Zip: _____

Insurance Company (Worker's Comp/Auto):_____ Phone _____ Claim No:_____

Adjuster: _____ Name of Insured: _____

Summary of Notice of Privacy Practices

Our Legal Duty We have the duty to protect the confidentiality of medical information about you. We are required to provide you with a Notice of Privacy explaining ways we may use and disclose your medical information. This notice also describes your legal rights and our obligations regarding the uses and disclosure of your medical information.

How We May Use and Disclose Medical Information About You. We may use or disclose identifiable health information about you for many reasons including but not limited to:

Treatment	Activities of managed care networks in which we participate	Payment
Activities of our affiliates	Health Care Operations	Appointment reminders
Health Oversight Activities	Individuals involved in your care or payment	Auditing
To avert a serious threat to health & safety	Coroners, Medical examiners and funeral directors	Research
Lawsuits and disputes	As required by law	Workers Compensation
To military command authorities	Law Enforcement purposes	National Security & Protective Services

In general, other uses and disclosure of your medical information will require your written authorization.

Your Privacy Rights

You have the following right with respect to your health information;
The right to request confidential communications and alternative means to communication to you
The right to request restrictions on certain uses of your health information
The right to inspect and copy certain medical information that we maintain about you
The right to request any amendments of your health information
The right to an accounting of certain disclosures of your health information

Changes to this Notice: We reserve the right to amend his notice in the future. A revised notice will be made available to you upon request

Complaints: If you believe your rights have been violated you may file a written complaint with our Policy Officer at (478) 374-4305 or with the Secretary of the U.S. Department of Health and Human Services.

More information: This form contains only a summary of our policy practice in accordance with the Health Insurance Portability and Accountability Act. If you have any further questions, feel free to ask the Technologist. If the Technologist cannot answer your questions to your satisfaction you will be provided with an unsigned copy of this form to take to an attorney who is familiar with H.I.P.A.A

The technologist reserves the right to refuse to perform an ordered exam or study until all forms are completed and signed by the patient or representative

ACKNOWLEDGEMENT

Patient Name:_____

Patient Acknowledgement: I acknowledge that a copy of the Notice of Privacy Practice for MedCross Imaging PC has been available to me. I acknowledge that I have been provided with the opportunity to ask questions regarding the Notice and its contents.

Signature of Patient:_____Signature of Med Cross Imaging, LLC Rep:_____