**Welcome to Diagnostic Imaging/ Memphis Radiological, P.C.**

Our goal is to provide excellent service.

The following information will allow us to accurately handle your billing and insurance.

**Date Referring Physician Primary Care Physician**

(Referring and Primary Care physician may receive your medical records)

**Please present Insurance Card and Photo ID at check in time**

Patient Name Date of Birth / / SSN

o Male o Female Marital Status: o Married o Widowed o Single o Divorced

Mailing Address City State Zip

County Email Address

Home Phone Work Phone Cell Phone Spouse/(Next of Kin) Relationship Phone Emergency Contact Relationship Phone Employer Work Phone Pharmacy Phone

**How may we contact you regarding appointments and medical information?** o **Home** o **Work** o **Cell** o **Email**

**Where may we leave a message?** o **Home** o **Work Phone** o **Cell Phone**

**May we communicate with you via-non-encrypted email including Protected Health Information which does include but may not be limited to appointments, normal test results?** o **Y** o **N**

*Prior to providing an email address or telephone number, you should consider that communications via these means are unsecure and consider whether to provide a personal or a work email address or telephone number. If you choose to provide a work email address or telephone number, potentially-sensitive information may reside under the control of your employer. By providing an email address or telephone number below, you acknowledge and assume the risks of transmitting information via unsecure means.*

**Race** \_\_ Caucasian/White \_\_ African American/Black \_\_ American Indian \_\_ Asian \_\_ Other

**Ethnic Background** \_\_ Hispanic \_\_ Non- Hispanic **Preferred Language**

**Primary Insurance** Policy Number Group Number

Policy Holder’s Name Policy Holder’s SSN

Policy Holder’s Date of Birth / \_\_\_/\_\_\_\_\_\_

Policy holder’s address (if other than patient) City State Zip

**Secondary Insurance** Policy Number Group Number

Policy Holder’s Name Policy Holder’s SSN

Policy Holder’s Date of Birth / \_\_\_/\_\_\_\_\_\_

Policy holder’s address if other than patient City State Zip

Date Patient Signature (or guardian) Relationship if not patient

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| --- | --- |
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**Authorization for Use and Disclosure of Protected Health Information**

Patient Identification - Please Print

Full Name: Date of Birth: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Home Address: City:

State: Zip: Home Telephone #: (\_\_\_\_\_\_\_) \_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_

Information To Be Released – Covering the Periods of Healthcare

From: (date) TO: (date)

Type of Information To Be Released – Please check only those that apply

🞎 Complete health record (or) 🞎 Imaging reports (e.g. X-ray, MRI) 🞎 Progress notes

🞎 History 🞎 Complete billing record 🞎 Films / images (e.g. X-ray, MRI)

🞎 Imaging results 🞎 Consultation reports 🞎 Itemized bill

🞎 Other, (please be specific):

Purpose of Request

🞎 Treatment or Consultation 🞎 At the request of the patient 🞎 Billing or Claims Payment

🞎 Other, (please be specific):

Who and Where to Send/Release Information

Name:

Address:

City: State: Zip:

Telephone #: (\_\_\_\_\_\_\_) \_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_

Time Limit and Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization, I can, at any time, revoke this authorization by submitting a notice in writing to the Privacy Officer at Memphis Radiological, P.C. (MRPC)/DI, 6401 Poplar Ave #100, Memphis, TN 38119]. Unless revoked, this authorization will expire on the following date or event at the end of the year, or 180 days from the date of signature.

Re-Disclosure

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act of 1996. MRPC/ DI, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient or Personal Representative Who May Request Disclosure

I understand that I do not have to sign this authorization, and my treatment or payment for services will not be denied if I do not sign this form unless specified above under Purpose of Request. I can inspect or copy the protected health information to be used or disclosed.

**I authorize Diagnostic Imaging to release the protected health information specified above.**

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

Signing Authority (if not patient): Relationship:

Identity of Requestor Verified via: 🞎 Photo ID 🞎 Matching Signature 🞎 Other (specify):

Verified by: Printed Name:

**FINANCIAL POLICY**

Thank you for choosing Memphis Radiological, P.C. (MRPC) as your health care provider. Because healthcare reimbursement is a complex and sometimes complicated system, we need your help to ensure your insurance benefits are maximized. The following is a statement of our Financial Policy which you will need to read and sign prior to any services. We also require all patients to give us complete demographic and insurance information prior to or upon arrival at our offices.

**Insurance Coverage**

We accept assignment of insurance benefits. We will file a claim with your insurance company for any services you receive. The balance of your account after insurance pays is your responsibility. We cannot bill your insurance company without your insurance information and a copy of your insurance card(s): You are responsible to inform us if you have more than one insurance carrier and which carrier is primary and which is secondary. Your insurance policy is a contract between you and your insurance company. If your insurance company has not paid your account in full within 120 days of the date of service, the balance will be automatically transferred to you.

Each insurance plan has different policies regarding how often services may be rendered and, more importantly, where those services may be performed. Even within the same insurance company, plans can offer different benefits, depending on what your employer has negotiated. We strongly urge you to be familiar with your policy benefits, especially whether you can have radiology services in our office.

**Patient Responsibility**

All co-pays required by your insurance company must be paid at the time of service. This payment is a requirement by your insurance company. We cannot bill for co-pay amounts.

All co-insurance and deductible amounts must be paid within 30 days of your insurance payment or determination of benefits from your insurance carrier.

If your insurance coverage changes for any reason, it is your responsibility to inform our office and to provide any new insurance information along with a copy of your new card.

**For patients with no insurance coverage**

If you do not have insurance coverage, payment for services is expected at the time services are rendered. Our policy is to reduce the usual and customary rates charged to uninsured patients to approximate the payment rates allowed by private insurance companies in the market. If you do not have insurance benefits, you should contact our office prior to your visit to discuss payment options.

**For patients involved in an automobile or other accident**

We accept assignment of insurance benefits for patients involved in an auto accident. We will file a claim with your health insurance company for any services you receive. It is your health insurance company’s responsibility to subrogate the claim with your auto insurance or any other party responsible for the accident. We cannot bill the insurance company unless you give us the insurance information and a copy of your insurance card(s). You are responsible to inform us if your visit is related to your auto accident. The balance of your account is your responsibility regardless of payment from your insurance carrier. Your insurance policy is a contract between you and the insurance company. If your insurance company has not paid your account in full within 120 days from the date of service, the balance will be automatically transferred to you. We will not accept assignment from any other third party in relation to an automobile accident.

**Contact Information**

Following your visit to the office we will file a claim with your insurance company if you have coverage. After we have received payment from your insurance company you will receive a statement showing the balance due from you. This amount is your responsibility and is due within 30 days of the statement date. A return- addressed envelope will be included for you to mail in your payment or you may make payments at any of our offices: We accept cash, checks, Visa, MasterCard, Discover or American Express.

**Assignment of Benefits**

I request that payment of authorized benefits be made on my behalf to MRPC for any services furnished the patient listed above by MRPC personnel, and I assign my right to receive these payments to MRPC. I authorize MRPC to file an appeal on my behalf for any denial of payment and/or any adverse benefit determination related to services and care provided. If my health insurance plan will not remit payment to MRPC, I agree to forward to MRPC all health insurance payments, which I receive for the services rendered by MRPC and its personnel.

I authorize MRPC or its subcontractors to release to my health insurance plan such information needed to determine these benefits or the benefits payable for related services.

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Person Legally Responsible Relationship to Patient Date

**Patient Responsibility**

I acknowledge that I am responsible for all charges for services provided to the patient listed above which are not covered by my health insurance plan or for which I am responsible for payment under my health insurance plan. To the extent no coverage exists under my health insurance plan, I acknowledge that I am responsible for all charges for services provided and agree to pay all charges not covered by insurance. I further agree that, if permissible by law, I will reimburse MRPC for all costs, expenses and attorney’s fees that may be incurred by MRPC to collect those charges.

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Person Legally Responsible Relationship to Patient Date

**CONSENT TO TREAT**

Please read the text below and sign at the bottom to provide consent for treatment.

**Informed Consent to Screen, Evaluate and Treat**

As a patient of Memphis Radiological, P.C. or Diagnostic Imaging (MRPC), I have the right to make informed decisions regarding my care. My rights include being informed of my health status, being involved in care planning and treatment, and being able to request or refuse treatment. MRPC healthcare professionals will discuss with me the nature of my symptom(s) and condition(s), the proposed treatment(s), the benefits and risks associated with treatment, the probability of successful outcomes, and alternatives to the proposed treatment(s), if any or as applicable. I acknowledge and understand that I may revoke consent to further care at any time by informing MRPC at 901-387-2340 or my MRPC healthcare professional of my desire to do so.

By accepting screening, evaluation, diagnosis, and treatment from any MRPC healthcare professional, I authorize providers using the MRPC platform to perform all clinical and professional treatment and services deemed necessary in their determination in order to ensure treatment outcomes/appropriateness and acknowledge that I have been informed of the benefits and risks of such treatment and services by the MRPC healthcare professional(s) providing my care.

I do hereby authorize MRPC/ DI to provide me treatment services as needed for the performance of radiology and imaging related to the evaluation, diagnosis, and treatment of my health conditions.

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

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**COMMUNICATION PREFERENCES AND CONSENT**

In an effort to communicate with you in the manner in which you prefer, we are asking for permission to contact you via email, telephone calls to your landline or cellular telephone (including prerecorded/artificial voice messages and/or calls from an automatic dialing device), voicemails, and/or text messages. Communications may be made by or on behalf of MRPC/ DI to confirm an appointment, to obtain feedback, or to provide health reminders and health care information and services. We do not charge for these communication options, but standard text messaging rates, data pricing, and/or cellular telephone minutes may apply as provided in your telephone service plan (contact your carrier for pricing plans and details).

**AUTHORIZATION AND CONSENT**

Please complete this section by initialing next to **some or all** of the options below and by providing the relevant contact information. Prior to providing an email address or telephone number, you should consider that communications via these means are **unsecure** and consider whether to provide a personal or a work email address or telephone number. **If you choose to provide a work email address or telephone number, potentially-sensitive information may reside under the control of your employer**. The transmission of protected information via unsecure/unencrypted email or text messages presents many risks, such as:

1. Emails and text messages can be intercepted, altered, forwarded, circulated, misdirected, stored, and/or used without authorization or detection.
2. Copies of emails and text messages may exist in backups, or otherwise, even after the sender and the recipient have deleted the messages.
3. Emails and text messages can introduce viruses and other malware into your computer or other device.
4. Emails and text messages can be falsified more easily than handwritten or signed documents.
5. Employers and online service providers may have a right to inspect any email transmitted through their systems.

By providing an email address or telephone number below, you acknowledge and assume the risks of transmitting information via unsecure means. **I authorize** **and consent** to the use and receipt of:

**All of the following:**

*Text messages* for appointment reminders, feedback, health information, and health care information and services, and **the cell phone number is** .

*Cellular telephone calls and voicemails* for appointment reminders, feedback, health information, and health care information and services, and **the cell phone number is** .

*Landline telephone calls and voicemails* for appointment reminders, feedback, health information, and health care information and services, and **the telephone number is** .

*Email messages* for appointment reminders, feedback, health information, and health care information and services, and **the email address is** .

**Authorization and Consent**

I hereby consent and authorize MRPC to use, disclose, and release my protected health information and to contact me as described above. I understand that this authorization is voluntary, that the information to be used and disclosed is protected by law, and that the use/disclosure is to be made to conform to my directions.

Information used and/or disclosed pursuant to this authorization will not be protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and may also be re-disclosed by the recipient, unless otherwise prohibited by law. MRPC, its employees, officers, health care providers, and other workforce members are hereby released from any legal responsibility or liability for any use or disclosure of the above information to the extent indicated and authorized herein.

I acknowledge and agree that I have read and understand the foregoing, have had an opportunity to ask questions, and have had all of my questions answered. I have the full legal authority to agree to and to sign this authorization myself or on behalf of the party identified in the registration process. I understand that by signing this form, I am authorizing the use and/or disclosure of confidential protected health information and the use of the communication methods in accordance with my instructions above for the purposes identified.

**Patient Signature:** **Date:**

*If you are not the patient, but are signing on behalf of the patient, please complete the following and provide supporting documentation*

I, , confirm that I am the legal representative of the patient identified above

(print name)

based upon the following relationship:

**Representative’s Signature:** **Date:**

**OPT-OUT/REVOKE CONSENT**

If you have previously consented to the use and receipt of communications via email, telephone calls to your landline or cellular telephone, voicemails, and/or text messages and you wish to remove/opt out/revoke your consent to the use and receipt of email, text message, telephone calls, or voicemails (in other words, you do not want your email address or telephone number(s) to be used for the above-mentioned communications in the future), you may complete and submit this revocation form as outlined above. I hereby revoke my authorization and consent to the use and receipt of appointment reminders, feedback, health information, and health care information and services via:

*text messages*

*cellular telephone calls and voicemails*

*landline telephone calls and voicemail*

*email messages*

**Patient Signature:** **Date:**

*If you are not the patient, but are signing on behalf of the patient, please complete the following and provide supporting documentation*

I, , confirm that I am the legal representative of the patient identified above

(print name)

based upon the following relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Representative’s Signature:** **Date:**