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: _____

(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#: _____

☐ Male ☐ Female Marital Status: ☐ Married ☐ Widowed ☐ Single ☐ 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: _____

How may we contact you regarding appointments and medical information?
☐ Home ☐ Work ☐ Cell ☐ Email
Where may we leave a message? ☐ Home ☐ Work Phone ☐ 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? Yes No
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 Nr. _____
Policy Holder's Name: _____ Policy Holder's DOB: _____
Policy Holder's SSN: _____
Policy holder's address (if other than patient): _____
City: _____ State: _____ Zip: _____
Secondary Insurance: _____ Policy Number: _____ Group Nr. _____
Policy Holder's Name: _____ Policy Holder's DOB: _____
Policy Holder's SSN: _____
Policy holder's address (if other than patient): _____
City: _____ State: _____ Zip: _____

_____ Date: _____
Patient Signature (or guardian) Relationship if not patient

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.

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.

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: _____

Authorization Form Release of Information

For information about how your medical information may be used or disclosed, please see the Patient Notice. You have the right to review the Notice before you decide to sign this form. The Notice is subject to change. The Notice is posted at Diagnostic Imaging and on our website at www.diagnosticimagingpc.com.

- YOU HAVE THE RIGHT TO INSPECT, COPY AND/OR AMEND INFORMATION TO BE USED OR DISCLOSED.
- YOU MAY REFUSE TO SIGN THIS FORM, HOWEVER IT MAY PREVENT US FROM COMPLETING A TASK YOU HAVE REQUESTED.
- WE WILL NOT CONDITION YOUR TREATMENT ON AN AUTHORIZATION, EXCEPT FOR AN AUTHORIZATION FOR RESEARCH-RELATED TREATMENT.
- WE MUST PROVIDE YOU WITH A COPY OF THIS AUTHORIZATION FORM UPON REQUEST.

I, _____, (please print your full legal name)

hereby give the following people permission to receive information from this office on my behalf:

Name of Person _____ Relationship to me (e.g. Parent, friend, spouse)
Name of Person _____ Relationship to me _____
Name of Person _____ Relationship to me _____

~~(Signature)~~ _____ ~~(Date)~~ _____

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 (SMS) messages for appointment reminders, confirmationts and appointment information and services, **and the cell phone number is** _____

By checking this box, I consent to receive SMS from Diagnostic Imaging. Reply STOP to opt-out; Reply HELP for support; Message & data rates may apply; Messaging frequency may vary. Visit https://diagnosticimagingpc.com/privacypractices/ to see our privacy policy and for our Terms of Service."

☐ 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 voicemail/s 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.

I agree Memphis Radiological PC dba Diagnostic Imaging and their agencies, attorneys, or collection agencies may contact me regarding medical information or information about my account or for the purposes of collection by telephone at any number provided by me including wireless telephone numbers, and via text messaging or email to any email address provided. Methods of contact may include the use of pre-recorded or artificial voice messages and/or automated dialing.

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 Signature: _____ **Date:** _____

MEMPHIS RADIOLOGICAL, P.C.
& DIAGNOSTIC IMAGING
NOTICE OF PRIVACY PRACTICES

Patient Name: ___ **Date of Birth:** _____

By signing below, I acknowledge and agree that I have reviewed a copy of the Memphis Radiological, P.C. (MRPC) (at Diagnostic Imaging) Notice of Privacy Practices, that I have had an opportunity to review my rights related to my health information, and that I have been notified of how MRPC may use and disclose my health information, including in relation to MRPC's participation in an Organized Health Care Arrangement. I have been provided an opportunity to ask questions about the Notice of Privacy Practices and its contents.

Patient Signature: _____ **Date:** _____

If you are <u>not</u> 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:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Telephone: _____

Office Use Only

If the patient or his/her authorized representative does not sign above, please indicate which of the following good faith efforts were made to obtain a signed Acknowledgement. Please document the efforts that were made with dates, times, individuals spoken to, and outcome, as applicable.

☐ In-Person Conversation _____
☐ Telephone Contact _____
☐ Other _____

Name: _____ **Title:** _____

Signature: _____ **Date:** _____