PATIENT REGISTRATION FORM

Name: ____ Gender: M ____ F ____ Marital Status: ____
Last First MI

Address: ______________________ ______________________ ______________________
Street City, State Zip

Billing Address: ______________________ ______________________ ______________________
Street City, State Zip

Phone(s): ______________________ ______________________ ______________________
Home Cellular Other

Demographics: ______________________ ______________________ ______________________
Date of Birth Social Security Driver's License

Employer: ______________________ ______________________ ______________________
Name Occupation Work Phone

Employer Address: ______________________ ______________________ ______________________
Street City, State Zip

Emergency: ______________________ ______________________ ______________________
Emergency Contact Name Relationship Phone

Insurance Information

	Primary Insurance Company	**Secondary Insurance Company**
Insurance Company to be billed on my behalf:	______________________	______________________
Subscriber's Name (Policy Holder):	______________________	______________________
Subscriber's Date of Birth (Policy Holder):	______________________	______________________
Subscriber's Relationship to Patient, if not the same	______________________	______________________

Worker's Compensation / Personal Injury

Were you injured at work? Yes ____ No ____ Date of Injury ______________________

Were you injured as the result of an automobile accident? Yes ____ No ____ Date of Injury ______________________

Consent for Treatment & E-mail Communication

I voluntarily consent to routine procedures and other treatment by Desert Medical Imaging professionals and their assistants, appointees or consultants as is required in their judgment. I am aware that the practices of medicine, surgery and other health disciplines do not constitute exact sciences. I acknowledge that no guarantees have been made to me as to the result of treatments or examinations at Desert Medical Imaging.

I understand that for certain procedures deemed necessary by my physician, I may be required to sign a special consent form. Further, if I do not fully understand a procedure or its risks, consequences, and alternatives, I have the right to question the appropriate health care professional(s).

I understand that Desert Medical Imaging shall not be responsible or liable for loss of or damage to personal property.

I have read the above statements and the questions have been answered to the best of my abilities. I hereby certify that I understand its contents.

By providing my e-mail address either by written form below or in verbal communication, I hereby authorize Desert Medical Imaging to communicate with me via e-mail for such services as, but not limited to, sending of patient records, receipts for payments, and any other notifications or announcements. I further authorize for Desert Medical Imaging to communicate with my physician(s) via electronic methods regarding my health records.

______________________ ______________________
Patient Name (Printed) e-mail Address

______________________ ______________________
Financial Responsible Party's Name (Printed) Relationship to Patient

______________________ ______________________
Signature of Patient or Subscriber Date

ASSIGNMENT OF BENEFITS

Precertification Responsibility:
I understand that it is the insurer's responsibility to review anticipated courses of treatment. I understand that if the insurer determines that the treatment plan is necessary and appropriate and issues certification, the benefits of my health plan will be available to me according to my policy terms. However, if certification is denied, benefits may be withheld. I understand that precertification is the responsibility of the patient, financially responsible party, and /or the referring physician. I also understand that I will be financially responsible for any and all related charges incurred as a result of this treatment plan should the insurer either refuse to precertify the treatment or retrospectively determine that a specific service was inappropriate, or should the certification occur too late to be valid. I understand that to protect myself from unnecessary personal financial obligations, I must review my obligations with my insurance company and personal physician in advance of my appointment.

I have read, understand and accept the above precertification responsibility _________ (Initials)

Assignment of Benefits:
In consideration if the services provided to me by Desert Medical Imaging, I hereby authorize, assign, and transfer payment of any and all benefits due to me under the terms of any insurance policy or policies that may cover the procedure performed on me directly to Desert Medical Imaging on any claim from submitted to my insurance carrier. I understand that this assignment does not relieve me of any financial responsibility that I may have for payment of charges not paid for by the insurance company, such as deductibles, coinsurance, co-pays, or denied claims.

I have read, understand and accept the above assignment of benefits _________ (Initials)

Authorization for Release of Medical Information:
I authorize any insurance company, employer, hospital, physician, psychologist, agency, or utilization review representative to release to Desert Medical Imaging any and all information with respect to me, which may have a bearing on any benefits payable by my insurance company for the procedure performed on me. I hereby designate Desert Medical Imaging, and/or their authorized agents as my authorized representative to pursue my appeal rights.

I have read, understand and accept the above release of information _________ (Initials)

Financial Responsibility:
I understand that my insurance company is being billed as a courtesy to me and that I am financially responsible for charges not covered by the Assignment of Benefits. One such charge may be my patient responsibility as dictated by a deductable, co-insurance, or co-payment responsibility required by my insurance carrier. Desert Medical Imaging may require an up-front payment by me for the estimated patient responsibility. I understand that any amount collected by Desert Medical Imaging from me is considered only an estimate until such time as the claim has been fully processed by my insurance carrier. Desert Medical Imaging may not know whether benefits will be denied until the insurance carrier had processed the claim. I hereby individually obligate myself to pay my account with Desert Medical Imaging in accordance with regular rates and terms of Desert Medical Imaging, in the event that the account remains unpaid by the insurance carrier after sixty (60) days from the procedure date. Should the account be referred to an attorney or a collection agency for collection, I shall pay reasonable attorney's fees and collection expenses.

I have read, understand and accept the above financial responsibility _________ (initials)

For all instances above wherein the document refers to the patient in the first person, the definition of said person also extends to my dependant(s) or those in my care for which I am financially responsible.

I HAVE READ, UNDERSTAND AND ACCEPTED MY RESPONSIBILIES AND AUTHORIZED AN ASSIGNMENT OF MY BENEFITS TO DESERT MEDICAL IMAGING AS FURTHER DESCRIBED ON THEIS FORM. I HEREBY CONSENT TO EACH OF THEM. THIS AUTHORIZATION SHALL REMAIN IN EFFECT UNTIL REVOKED IN WRITING BY THE UNDERSIGNED.

____
Patient Name (Printed)

____ _____________________________
Financial Responsible Party's Name (Printed) Relationship to Patient

____ _____________________________
Signature of Patient or Responsible Party Date

PATIENT CONSENT FORM TO USE, DISCLOSE COMMUNICATE AND DELIVER PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

By signing this form you are granting consent to Desert Medical Imaging to Use, Disclose, Communicate and Deliver your protected health information for the purposes of treatment, payment and healthcare operation. Our *"Notice of Privacy Practices"* provided more detailed information about how we may Use and Disclose your protected health information. You have a legal right to review our *"Notice of Privacy Practices"* before you sign this consent, and we encourage you to read it in full.

You have a right to request us to restrict how we Use, Disclose and Communicate your protected health information for the purposes of treatment, payment or health care operations. We are not required by law to grant your request. However, if we decide to grant your request, we are bound by agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

By signing this form you are granting consent to Desert Medical Imaging to disclose your personal health information about you to your physician, family, close personal friends, or any person that you identify, as long as the information disclosed to those individuals is relevant to their involvement in your care or the payment for your care. Desert Medical Imaging also may notify a family member or another person who is responsible for your care of your location and general health condition.

Please specifically identify any non-family close personal friend(s) that you authorize a release of your personal health information to: ____

By signing this form you are granting consent to Desert Medical Imaging to communicate and/or deliver to you directly or on your behalf to a person involved in your care via telephone, facsimile, e-mail, text, mail, or by leaving a message for purpose of, but not limited to, forwarding of medical records, healthcare communications, payment follow-up and any other necessary operational needs for the treatment and payment of your healthcare.

If you wish to not disclosure your personal health information to any physician, family, close personal friend, please indicate so by initialing below and marking the individual(s) that you wish to limit access to.

(**Initial**)_________ **I object** to my personal health information being disclosed to a ☐ family member, ☐ close personal friend or ☐ Physician involved in my care.

If you wish to deny certain methods of communication, please indicate so by initialing below and marking the type(s) of communication that you are rejecting. Depending upon your rejection, you may have to coordinate the delivery of medical records yourself.

(**Initial**)_________ **I object** to my personal health information being communicated or delivered to me or a person involved in my treatment through the use of ☐ telephone, ☐ facsimile, ☐ e-mail, ☐ text, ☐ mail or by ☐ leaving a message.

____
Patient Name (Printed)

____ _____________________________________
Financial Responsible Party's Name (Printed) Relationship to Patient

____ _____________________________________
Signature of Patient or Responsible Party Date

DESERT ▪ MEDICAL ▪ IMAGING

John F. Feller, M.D., Medical Director
Christopher R. Hancock, M.D. • Stuart T. May, M.D. • Adam J. Brochert, M.D.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

To (Medical Provider): ____
(Name of Doctor, Hospital, Facility, etc…)

Address: ____

____

____

I, ____, hereby authorize the release of my medical information to Desert Medical Imaging to be used for the purposes of evaluating my imaging procedure(s). Please forward to Desert Medical Imaging my medical history including but not limited to, medical reports, films/CD, prior imaging studies or other pertinent information for the following complaint(s):

____
(Nature of Illness or Injury)

Please send the medical records to:

Desert Medical Imaging
74785 Highway 111
Suite 101
Indian Wells, CA 92210
Attn: Medical Records

Patient Name: ____________________________ Date of Birth: ____________________________

Signature: ____________________________ Date: ____________________________

If you have any questions, you may reach the medical records coordinator direct at (760) 766-2039.

Thank you for your courtesy.
Desert Medical Imaging

DESERT MEDICAL IMAGING
PATIENT HISTORY AND SAFETY SCREENING FOR CT

NAME ____ DATE __________

DATE OF BIRTH __________________________________ AGE __________

PLEASE CHECK YES OR NO TO THE FOLLOWING:

YES	NO	
○	○	Kidney Failure
○	○	Diabetic? If yes, are you on glucophage / metformin therapy? _______
○	○	Multiple Myeloma (a form of bone cancer)
○	○	Asthma
○	○	Heart Disease
○	○	Chronic Obstructive Pulmonary Disease (COPD)
○	○	Allergy to Iodine
○	○	Personal History of Cancer? If yes, Please specify _______________
○	○	Females: Is there a chance you might be pregnant?
○	○	Did you drink 32 ounces of water?
○	○	Have you eaten in the past 4 hours?
○	○	Have you had a CT scan of the study we are doing today? *
		If so, where? ____________________________________
○	○	Have you had a PET scan? *
		If so, where? ____________________________________

* If you answered “Yes” to the last two questions please fill out the authorization form included in this packet so we may obtain copies of the report(s).

NOTE: *An Intravenous contast may be used in your CT scan study*

____
Signature of Patient