Mid Rogue IMAGING CENTER

1619 NW Hawthorne Suite 102
Grants Pass, Oregon 97526
Phone: 541.472.5154
Fax: 541.472.5178

PATIENT REGISTRATION

Please answer the following questions. If you need any assistance please, do not hesitate to ask.

Patient Name (Last) _____ (First) _____ (Middle) _____

Parent/Guardian (Last) _____ (First) _____ (Middle) _____

Mailing Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Gender ☐ M ☐ F DOB _____

Marital Status ☐ Married ☐ Single Spouse's Name _____

EMPLOYMENT

Occupation _____ Employer _____

Employer Address _____

City _____ State _____ Zip _____

Work Phone _____ Social Security # _____

EMERGENCY CONTACT

Name (other than spouse) _____

Relation _____ Best Phone _____

BILLING

As a courtesy, Mid Rogue Imaging Center (MRIC) will bill your insurance company. However, please remember that you, the patient, are responsible for the bill. Any unpaid balance will be billed to you.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize MRIC to release any information or medical records to any physician, hospital, medical facility or insurance company dealing with my health care.

I am financially responsible for the timely payment of my outstanding bill per MRIC policies. I will be responsible for any and all collection agency fees up to 25% of the amount placed with the collection agency. In the event MRIC seeks legal action for collection on my accounts, I will also be responsible for any and all fees associated with court costs, garnishment and/or attorney fees.

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of Mid Rogue Imaging Center's Notice of Privacy Practices.

Printed name of patient or responsible party _____

Signature _____ Date _____