MID ROGUE IMAGING CENTER

Your Community | Your Health | Your Choice

PATIENT REGISTRATION FORM

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

Mailing Address: _____

_____
(City) (State) (Zip Code)

Home Phone: _____ Cell Phone: _____

Sex M/F: _____ Date of Birth: _____ Marital Status: M/S _____

Social Security Number: _____ Email: _____

Occupation/Employer: _____ Employer Phone: _____

Employer Address: _____

_____
(City) (State) (Zip Code)

Emergency Contact

Emergency Contact Name: _____

Relation: _____ Phone Number: _____

Patient Responsibility

- To know your insurance policy, for example, if there is a co-pay or deductible; whether coverage has lapsed or expired at the time of service.
- I understand I, the patient, am financially responsible for my health insurance deductible, co-insurance, or non-covered service.
- Co-payments are due at time of service.
- If my plan requires a referral, it must be obtained prior to my visit.
- We, MRIC, may verify your insurance benefits or submit your claim to your insurance carrier as a courtesy for you. You agree to facilitate payment of claims by contacting your insurance carrier when necessary.
- In the event my health plan determines a service to be "not payable", I will be responsible for the complete charge and agree to pay the costs of all services provided.
- If I am Self-Pay or uninsured, I agree to pay for the medical services rendered to me at time of service.
- By signing below, I understand, I am responsible for all collection agency fees up to 25% of the amount placed with the collection agency. In the event legal action is sought for collection on my account, I am also responsible for any and all fees associated with court costs, garnishment and/or attorney fees.

_____ _____
(SIGNATURE OF PATIENT OR RESPONSIBLE PARTY) (DATE)