LIVINGWELL RADIOLOGY

Patient Registration

Last Name _____ **First Name** _____ **Middle Int.** _____ **Sex M** or **F**

Ordering Physician _____ **Social Security No.** _____-_____-_____ **DOB** ____/_____/_____

Address_____ **City** _____ **ST**_____ **Zip**_____

Home Phone (____) ____-_____ **Cell Phone** (____) ____-_____ **E-mail** _____

Employer _____ **Work Phone** (____) _____

Emergency Contact _____ **Phone** (____) _____ **Relationship** _____

1st Primary Insurance _____ **Policy Holder Date of Birth**____/____/____

Guarantor Name _____ **DOB** ____/_____/_____ **Relationship** ☐**Self** ☐**Spouse** ☐**Child**

2nd Insurance_____ **Guarantor Name** _____ **DOB** ____/_____/_____

ASSIGNMENT OF INSURANCE BENEFITS INCLUDING MEDICARE AND MEDICAID

I hereby authorize LIVINGWELL RADIOLOGY, P.S.C. to release any medical or incidental information that may be necessary for either medical care or in the processing of medical claims for payment of services. This authorization includes benefits to include Medicare, Medicaid and other third party carriers directly to LIVINGWELL RADIOLOGY, 2421 BROADWAY OR 2371 New Holt Rd for any services performed. I understand that I am responsible for all charges regardless of insurance status as well as any associated cost which may be up to 24% for collection services if collection action is needed. I also agree that LWR or a collection agency may contact me through cell phone calls or text msg. and I will assume all personal phone fees which may result. I agree that this authorization shall be valid until rescinded in writing or replaced one of a later date. A photocopy of this assignment shall be considered as valid as the original.

Refund Policy: In the event you are required to make a payment before services, any payment subject to a refund will incur a $3 processing fee for postage and handling. If upfront payment was made by credit card, a .045% will also be withheld from the refund due. $0 will be deducted if payment is made by cash or check and refund check is picked up at 2421 Broadway St. If you prefer how a refund is processed, you must request chart documentation at the time of payment.

Consent to Treatment

I hereby agree to be evaluated by LIVINGWELL RADIOLOGY, P.S.C. and/or one of his associates or appointees and that treatment may be rendered to me as deemed medically appropriate and/or necessary.

PRIVACY CONSENT FOR USE OR DISCLOSURE OR PATIENT INFORMATION FOR THE PURPOSE OF TREATMENT, PAYMENT, AND HEALTH CARE OPTIONS

I hereby consent to LIVINGWELL RADIOLOGY P.S.C., using or disclosing my protected health information for the purpose of providing treatment to me, obtaining payment for health care services rendered to me, or to carry out the Practice's health care operations. I also consent to LIVINGWELL RADIOLOGY P.S.C. using or disclosing my protected health information for treatment activities provided by another health care provider, as well as the payment activities conducted by another health care provider or entity. I further consent to the disclosure of my protected health information in order for another provider of health care entity to conduct health care operations including quality assessment and reviewing the competence of health care professionals.

- **I CERTIFY THAT THE INFORMATION GIVEN BY ME, APPLYING FOR PAYMENT, IS CORRECT.**
- **I HAVE READ ABOVE AND FULLY UNDERSTAND THE TERMS THEREOF.**
- **I FURTHER ACKNOWLEDGE THAT LIVINGWELL RADIOLOGY, P.S.C. HAS MADE AVAILABLE A COPY OF ITS NOTICE OR PRIVACY PRACTICES WHICH PROVIDES A DETAILED DESCRIPTION OF THE USES AND DISCLOSURES ALLOWED BY THE CONSENT AS WELL AS OTHER RIGHTS I HAVE REGARDING MY PROTECTED INFORMATION.**

Patient's Name (Please Print):_____ Date:_____

X Patient's or Guardian Signature: _____ Relationship_____