Patient Registration Form - Please Print

First Name _____ M.I. _____ Last Name _____

Birth Date _____/_____/_____ Gender _____ SS# _____

Marital Status: Single / Married / Other Doctor who referred you to our office _____

Patient Address _____ Apt# _____ City _____ ST _____ Zip _____

Home Phone _____- _____- _____ Cell Phone _____- _____- _____

Email Address _____

Employment Status: ☐ Employed ☐ FT Student ☐ PT Student ☐ Self Employed ☐ Retired

Employer Name: _____ Employer Phone: _____-_____-_____

Emergency Contact Name: _____ Emergency Contact Phone: _____-_____-_____

Guarantor (Complete if patient is under age of 18 years)

Name: _____ SS#: _____ DOB: _____

Relationship to Patient: _____

Address (if different from patient): _____

Home Phone _____- _____- _____ Cell Phone _____- _____- _____

Guarantor Employment Status: ☐ Employed ☐ FT Student ☐ PT Student ☐ Self Employed ☐ Retired

Employer Name: _____ Employer Phone: _____-_____-_____

The information below is being collected pursuant to the requirements of the TN Department of Health in compliance with Tennessee state law.

Race: ☐ White/Black/American Indian ☐ Eskimo or Aleut ☐ Asian or Pacific Islander
☐ Other Race ☐ Unknown Race

Ethnicity: ☐ Hispanic Origin ☐ Not Hispanic Origin ☐ Unknown Hispanic Origin

Please check the appropriate box in answer to the following question. Have you executed an Advance Health Care Directive, a Living Will or a Power of Attorney? ☐ Yes ☐ No

On the Job Injury: ☐ Yes ☐ No Motor Vehicle Accident: ☐ Yes ☐ No Accident/Injury Date: _____ State: _____

Workers' Compensation Insurance - If work related injury, please provide us the following information:

WComp Insurance Name: _____ WComp Phone: _____-_____-_____

Claim Number: _____ Case Manager: _____

Adjuster: _____ Authorized by: _____

If this is a Motor Vehicle Accident see our Financial Policy regarding handling of claims.

Premier Radiology

Revised 5.6.2021

HEALTH INSURANCE INFORMATION

☐ Check here to indicate you do **NOT** have Health Insurance Coverage as of this date.

Primary Insurance _____ Policy/Member Number _____

Plan Name _____ Group Number _____

Relationship: Self/Spouse/Child/Other Subscriber Name _____

Subscriber Date of Birth _____/_____/_____ Subscriber SS# _____

Secondary Insurance _____ Policy/Member Number _____

Plan Name _____ Group Number _____

Relationship: Self/Spouse/Child/Other Subscriber Name _____

Subscriber Date of Birth _____/_____/_____ Subscriber SS# _____

If you are enrolled with Medicare, please *check* your Medicare Enrollment Type:

☐ 12 - Working Age beneficiary/spouse with an employer group health plan
☐ 13 - End-Stage Renal Disease (ESRD) beneficiary in Medicare coordination period with an employer health plan
☐ 14 - No-Fault, including auto/other
☐ 15 - Workers' Compensation
☐ 16 - Public Health Service or other federal agency
☐ 41 - Black Lung
☐ 42 - Veteran's Administration
☐ 43 - Disabled beneficiary under age 65 with large group health plan
☐ 47 - Other Liability Insurance

Request or Consent for Release of Medical Information or Records

I hereby authorize the following person(s) to have access to my medical and billing information as indicated on the HIPAA consent form which I signed.

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

In addition to sending my medical report to the ordering doctor, I also authorize the following physicians/practitioners/hospital to have access to my medical records for continuum of healthcare.

Physician or Hospital Name: **Premier Radiology**

Address: **28 White Bridge Pike, Nashville, TN 37205** Phone: **615.356.3999**

***DELINQUENT ACCOUNTS:** We review past due accounts frequently and at every statement cycle. Your communication and involvement to ensure your balance is paid timely is important to us. It is imperative that you maintain communications and fulfill your financial agreement and arrangements to keep your account active and in good standing.*

If your account becomes sixty (60) days past due, further steps to collect this debt may be taken. If you fail to pay on time and we refer your account(s) to a third party for collection, a collection fee will be assessed and will be due at the time of the referral to the third party. The fee will be calculated at the maximum percentage permitted by applicable law, not to exceed 18 percent. In addition, we reserve the right to deny future non-emergency treatment for any and all debtor-related unpaid account balances.

***CONSENT TO CONTACT:** I grant permission and consent to Premier Radiology and its agents, assignees, and contractors (which may include third party debt collectors for past due obligations): (1) to contact me by phone at any number associated with me, if provided by me or another person on my behalf; (2) to leave messages for me and include in any such messages amounts owed by me; (3) to send me text message or emails using any email address I provided or any phone number associated with me, if provided by me or another person on my behalf; and (4) to use prerecorded/artificial voice messages and/or an automated telephone dialing system (an auto dialer) as defined by the Telephone Consumer Protection Act in connection with any communications made to me as provided herein or any related scheduled services and my account. I understand that my refusal to provide the consent described in this paragraph will not affect, directly or indirectly, my right to receive healthcare services.*

MY SIGNATURE INDICATES THAT ALL INFORMATION REFLECTED ON THIS FORM IS TRUE AND ACCURATE

_____ _____/_____/_____

Signature of patient, responsible party or patient's representative **Date**

Front Desk Initials _____