

**Twin Peaks Medical Imaging, LLC
REGISTRATION FORM
To be completed by all patients**

***** PATIENT INFORMATION *****

Patient Name _____ Address _____
City _____ State _____ Zip _____ SSN _____
Phone _____ Sex _____ DOB _____ Weight _____

***** INSURANCE INFORMATION *****

Primary Ins _____ Insured ID # _____
Address _____ City _____ State _____ Zip _____
Secondary Ins _____ Insured ID # _____
Work Comp YES/NO _____ Auto Accident YES/NO _____
Date of Injury _____ Date of Accident _____
Adjuster Name _____ Adj Phone _____ Claim # _____

***** EMERGENCY CONTACT PERSON *****

Name _____ Relationship _____
Home Phone _____ Business Phone _____

***** GUARANTOR INFORMATION *****

Guarantor _____ Relationship _____
SSN _____ Address _____ City _____
Zip _____ Home Phone _____ Business Phone _____
Employer _____ Address _____
City _____ State _____ Zip _____

Twin Peaks Medical Imaging
Financial Policy

If you do not have insurance we do require a down payment of \$_____ which is due at the time of service. We do accept cash, check or credit card, Mastercard or Visa. If your insurance requires a referral form or pre-authorization, it is your responsibility to obtain one from your primary physician prior to being seen at TPMI.

Insurance is a method of reimbursing the patient for fees paid to the physician and is not meant to be a substitute for payment. It is your responsibility to pay any deductible, co-insurance or balance not paid by your insurer. By signing this document you understand that you are responsible for your bill and are subject to attorney and collection charges incurred if any portion of your bill is not satisfied.

Patient Authorization

I request that insurance payment be made to Twin Peaks Medical Imaging (TPMI) LLC. I authorize release of my medical records to other medical facilities involved in my health care and any insurance carrier for the purpose of processing this medical claim. This is in effect until I revoke it in writing.

I understand that the services, which I am having, may or may not be covered by my health insurance. I am aware that I can be billed and I am responsible for any existing or remaining balance after any adjustments have been made.

I have read and agree to the information on this form.

Patient Signature _____ Date _____

Acknowledgement of Receipt

Notice of Privacy Practices of Twin Peaks Medical Imaging (HIPPA April 14, 2003)

Patient Name: _____

Patients Date of Birth: _____

Patients Social Security Number (Optional) _____

Print Name if Parent Signing for a Minor or Guardian/Caregiver if signing for adult

Signature: _____

Date: _____