# STAR IMAGING

## PATIENT REGISTRATION FORM

**Referring Physician:** _____ **Today's Date:** _____

***Patient Information:***

Patient Name: _____ Date of Birth: _____

Sex: Male ☐ Female ☐ Marital Status: _____ SSN: _____

Address: _____City: _____State: _____Zip Code: _____

Phone # _____-_____-_____ Email: _____

Is Patient a Minor? Yes ☐ No ☐ If yes, parent/guardian name: _____

***Emergency Contact:***

Name: _____ Relationship to Patient: _____

Address: _____City: _____ State: _____ Zip Code: _____

Home Phone # _____-_____-_____ Cell # _____

***Insurance Information:***

☐ Check the box confirming Self-Pay Status

☐ Check the box if its accident/injury related

Primary Insurance:

Insurance Name: _____

Auto Insurance Name: _____

Policy #:_____

Claim #: _____

Group #:_____

Adjuster's Name: _____

Insured Name: _____

Adjuster's Phone #: _____

DOB: _____

Relationship to the patient: _____

***Consent and Acknowledgement***

I authorize Star Imaging to release any medical or other information needed for this or a related claim. If assignment is accepted, I request payment of insurance benefits be made directly to STAR IMAGING. I am responsible for the deductible, co-payment, and non- covered service (as determined by my insurer.) I understand that any deductible or coinsurance payments made on this exam date are estimates based on information STAR IMAGING received from my insurance company prior to submission of the claim for this exam. Once a claim is submitted to my insurance carrier for the exam, I understand that I may be responsible for additional amounts in accordance with my individual insurance plan and acknowledge that STAR IMAGING will bill me for the balance remaining. I authorize release of information, films, and copies pertinent to my medical history and for follow-up of any suspicious finding. This consent authorizes STAR IMAGING to release to my insurance company, referring physician and other physicians participating in my care my medical record, including images and reports.

**Signature of Patient/Parent/Guardian:** _____ **Date:** _____

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## AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION AND HIPPA AUTHORIZATION AND PROTECTED HEALTH INFORMATION CONSENT

Patient Name: _____ Date of Birth:_____

Your report will **automatically** be sent to the referring physician for today's visit. If you wish for a different provider to receive the report, please provide their name, and phone number.

**Release To:**

1. Name of Clinic/Provider: _____ PHONE:_____

2. Name of Clinic/Provider: _____ PHONE:_____

For the purpose of (Check at least one)

☐Continuity of Care by another Provider
☐Insurance
☐Disability
☐Other
☐Patient Request
☐Legal/Attorney
☐School

**Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information. Covered entities as that term is defined by HIPAA and Texas Health & Safety Code § 181.001 must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws. Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.**
I furthermore acknowledge that I have the right to designate access to my **PROTECTED HEALTH INFORMATION (PHI)** to anyone of my choosing. I hereby authorize disclosure of my **PHI** to the following individual(s)

**AUTHORIZED INDIVIDUALS**

1. _____ Relationship: _____

2. _____ Relationship: _____

**I understand I may revoke this authorization at any time by submitting a written request to Star Imaging, as per the office's Notice of Privacy Practices. I understand that by signing this authorization, this information will be used by Star Imaging to make determination for the release of my PHI. I also understand this authorization will remain in effect until I request an update an/or amendment.**

_____ _____
**PRINT NAME** **DATE**

_____
**SIGNATURE**