CARDIOVASCULAR IMAGING SERVICES, INC

Patient Registration Form (PLEASE PRINT)

Patient Name: Last _____ First _____ Patients DOB _____

Patient's SSN _____ Gender M___ F ___ Marital Statue S___ M___ D ___

Street address_____

City/State/Zip Code _____

Phone 1: _____ Type: Home____ Cell____

Phone 2: _____ Type: Home ____ Cell ___

Emergency Contact Name: _____

Emergency Contact Phone: _____

Patient's Email Address: _____

Employer: _____

Occupation: _____ Work Phone: _____

Employer Address: _____

City/State/Zip code: _____

RESPONSIBLE PARTY INFORMATION

Who will be responsible for your account? Self- ____ Other_____

Responsible Party Name: First_____ Last_____

Patient's Relationship to Responsible Party: _____

Responsible Party Street Address _____

City/State/Zip Code: _____

Home Phone Number: _____ Cell Phone: _____

INSURANCE INFORMATION (PLEASE PROVIDE INSURANCE CARD AND ID TO FRONT DESK)

Primary Insurance Company Name: _____

Insurance Address: _____

City/state/zip code: _____

Phone Number: _____

Member Id Number: _____Group Number: _____

Name of Policy Holder: First _____ Last _____

Policy Holders Date of Birth: _____ Policy Holder's SSN _____

Relationship to Patient: _____

Secondary Insurance, please compete this section:

Secondary Insurance Company Name: _____

Insurance Address: _____

City/state/zip code: _____

Phone Number: _____

Member Id Number: _____Group Number: _____

Name of Policy Holder: First _____ Last _____

Policy Holders Date of Birth: _____ Policy Holder's SSN _____

Relationship to Patient: _____

ASSIGNMENT OF BENEFITS OTHER THAN MEDICARE: I hereby assign and authorize payments for services rendered to be paid

directly to Cardiovascular Imaging Services, Inc. I understand that my insurance carrier(s) may not approve or reimburse my medical services in full due to usual and customary rates, benefit exclusions, coverage limits, lack of authorization or medical necessity. I understand that I am responsible for any charges not paid in full, co-payments, deductibles, and co-insurance except where my liability is limited by contract or state or federal law. A photocopy of this document shall be as valid and as effective as the original.

FOR MEDICARE PATIENTS ONLY: I certify that the information given by me in applying for payment under Title XVII of the Social Security Administration or its intermediaries or carriers is the correct information needed for Medicare claims. I hereby authorize any holder of medical or other information about me to release to the Centers for Medicare & Medicaid Services or its agents, intermediaries, or carriers any information needed to determine these benefits or the benefits payable for related services. I further understand that deductibles, coinsurance, and any other charges not covered by Medicare are my responsibility.

RELEASE OF MEDICAL INFORMATION: I authorize Cardiovascular Imaging Services, Inc to release the medical records concerning myself or my dependent to any physician, hospital or agency involved in the care of the patient listed on this form.

PAYMENT POLICY: Co-payments, Co-insurance and deductibles will be collected at the time services are rendered. We accept cash, checks, and credit cards. You will be responsible for any balance deemed patient responsibility/non-payable/non-covered by your insurance.

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE. I HAVE READ, UNDERSTAND, AND AGREE TO ABIDE BY THE ABOVE RELEASE OF MEDICAL INFORMATION AND PAYMENT POLICIE

Signature of Patient or Responsible Party: _____

(if under 18 years of age)

PATIENT HISTORY

Patient Name: _____ Patients Date of Birth _____
Type of Exam: _____ Date of exam _____

PLEASE ANSWER THE FOLLOWING QUESTIONS:

1. Is there any chance you could be pregnant? Yes_____ No _____
2. Date of last menstrual period (LMP) _____
3. List andy surgeries relate to your visit today. _____

_____
_____
_____

Patient Signature: _____ Date _____

Technologist notes HX: _____
_____
_____
_____
_____
_____

Patient Was Shielded: Yes _____ No Tech Initials: _____