PATIENT REGISTRATION

DESERT RADIOLOGY
a radiology partners practice

Patient Name:_____ DOB: _____

Street Address:_____ Apt. /Unit: _____

City: _____ State:_____ Zip Code: _____

Phone:_____ Cell: _____

Responsible Party Name: _____

Primary Insurance:_____ ID #: _____

Secondary Insurance:_____ ID #: _____

CONSENT TO COMMUNICATE VIA EMAIL:
I understand that authorized personnel from Desert Radiology may communicate with me regarding scheduling, follow-up on treatment provided, new services, locations or providers. I agree to receive communication via the email address provided below:

Email: _____

CO-PAY, CO-INSURANCE, DEDUCTIBLE PAYMENT POLICY:
All co-pays, co-insurance, deductible payments and outstanding balances are due **prior to services rendered**. If you are unable to make payment at the time of service, your exam will need to be rescheduled.

_____

Patient/Guardian Signature Date

FINANCIAL POLICY ACKNOWLEDGEMENT:
This Financial Responsibility Acknowledgement will remain in effect for one year from the date of signature. Desert Radiology will bill your insurance carrier for you. Patient/insured assigns all insurance benefits to Desert Radiology for services provided today. Patient/ insured assumes and agrees to pay all applicable deductibles, coinsurances and co-pays. Patient/insured agrees to pay for all non- covered services (preventive, screening or routine) that are not covered by the insurance company. Patient/Insured assumes responsibility for ensuring that insurance approved laboratory is utilized. Patient/insured understands that all returned checks are subject to a return check fee of $25.00. Please note that co-payment/deductible/coinsurance amounts quoted are estimates provided by your insurance carrier. You may receive a bill for additional amounts due from your service. Patient/insured is advised that Desert Radiology is contracted with an outside billing service. Imagine Pay will provide billing statements; they can be reached at 702-623-7568. Desert Radiology and or its billing/collections representatives may contact you by phone at any number associated with your account, including wireless numbers, which may result in charges to you. We may also contact you via text messaging or emails, using any email address you provided to us.

I further understand that it is my responsibility to ensure that laboratory approved by my insurance is used for any test/ biopsy results and that I must follow up with my referring physician directly regarding my test/biopsy results.

_____

Patient/Guardian Signature Date

_____ _____ _____

Patient/Insured Initials Date Patient/Insured Initials Date Patient/Insured Initials Date

_____ _____ _____

Patient/Insured Initials Date Patient/Insured Initials Date Patient/Insured Initials Date