DESERT RADIOLOGY

Patient Registration Form

Patient Name: _____ **DOB:** _____

Street Address: _____ **Apt. /Unit:** _____

City: _____ **State:** _____ **Zip Code:** _____

Home PH: _____ **Work:** _____ **Cell:** _____

Responsible Party Name: _____

Physician 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, educational information including newsletters as it relates to health related products or services available at DR, or alternative treatments, locations or providers. I agree to receive such communication via email at the email address provided below.

Email: _____

_____
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/Insured 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**