Adventist HealthCare Imaging

THE GEORGE WASHINGTON UNIVERSITY MEDICAL FACULTY ASSOCIATES MFA

Patient Registration Form

Last Name: _____ First Name: _____ Middle Initial: ____ DOB: _____

Sex: _____ Email: _____

Address 1: _____ Home Phone: _____

Address 2: _____ Work Phone: _____

City/State/Zip: _____ Employer: _____

Referring Physician(s):

1) _____

2) _____

Guarantor/Individual responsible for bill: _____

To Female Patients: Are you pregnant? ❑ Yes ❑ No ❑ Unsure Last Menstrual Period: _____

Exam related to an injury: If yes, date of injury: _____ ❑ Auto ❑ Work ❑ Other _____ State: ____

Primary Insurance

Insurance Name: _____

ID #: _____

Group #: _____

Policy Holder Name: _____

Employer Name: _____

DOB: _____ Sex: _____

SSN: _____

Relation to Patient: _____

Secondary Insurance

Insurance Name: _____

ID #: _____

Group #: _____

Policy Holder Name: _____

Employer Name: _____

DOB: _____ Sex: _____

SSN: _____

Relation to Patient: _____

PAYMENT POLICY

General: We may file insurance claim on behalf of the patient; however in the absence of any contractual arrangements to the contrary, the patient is always responsible for payment in full for services rendered, including, but not limited to, deductible amounts, copayment, balances due after insurance payment, or the full charge if there is no coverage for any reason. Notwithstanding any contractual arrangements, the patient or the subscriber is required at the time of service to present, as proof of coverage, a current and proper identification card from his or her insurance carrier showing sufficient client information to allow proper claims submission and payment. This will be further documented with positive identification or driver's license. In the absence of such proof, the patient or the subscriber is responsible for payment in full of the services rendered until such time as proof of insurance coverage is submitted, and is in compliance with the carriers claim filing time limitations. Any payor may require an insurance referral form to be completed by the patient's physician with appropriate authorization and/or precertification in order that reimbursement for services may be obtained. In the absence of the requisite referral form, the patient or subscriber will be responsible for payment in full for services rendered until such time as the requisite form is properly submitted.

I HAVE READ AND UNDERSTAND the above statements and agree to the provision as outlined.

❑ **Patient, Subscriber or Beneficiary Signature**: _____ Date _____

❑ **Receipt of Privacy Practices:** I certify that I have received, at this visit or a previous visit, a copy of Adventist HealthCare Imaging, Notice of Privacy Practices.

I give my permission for Adventist HealthCare Imaging to discuss my Protected Health Information with the persons listed below *(exclude all physicians)*.

Name _____ Relationship: _____