Gulf Imaging Open MRI and Digital Mammography **Date _____ Chart _____**

Patient Registration

Name _____
Last First Middle

Mailing Address _____
Street Apt #

_____
City State Zip

Phone _____ Work _____

Cell _____SSN # _____ DOB _____

Emergency contact _____

Relationship _____ Phone _____

Primary Insurance _____ secondary _____

If you ARE NOT the PRIMARY card hold (including Tri-care) we will need the following information to process your insurance. With out this information your insurance company can deny payment and the patient will be responsible for the services.

Spouse Name _____ DOB _____ SSN _____

AUTO ACCIDENTS INFORMATION

With out this information your auto insurance CAN NOT be processed and the patient will be responsible for the services.

Company **name** & **address**_____

Adjuster name _____ Phone & extension _____

Date of accident _____ Claim # _____

Release Agreement

1.) *I authorize **Gulf Imaging Open MRI** to release protected health information in the form of MRI or Digital Mammography diagnostic images to Bay Radiology and or another Florida Licensed radiologist firm; or, my referring physician for the purpose of a radiological read of the images and or other treatment.*
2.) *I authorize **Gulf Imaging Open MRI** to release information regarding my MRI/Mammo and/or my medical condition and treatment to my insurance company, physicians, attorney and/or any other health care professional involved in my medical care.*
3.) *I herby authorize **Gulf Imaging Open MRI** to obtain any medical records and/or reports from any physician, hospital or other facility. To be used for comparison, as well as my diagnostic.*
4.) *I authorize payment of benefits from my insurance coverage directly to **Gulf Imaging Open MRI.***
5.) *I understand that I am fully responsible for payment of all charges resulting from such medical treatment and that such charges are due and payable at the time of service, unless I have made other arrangements prior to this appointment.*

_____ _____

Signature **Date**

I authorize the following family/friends(excluding Doctors) to retrieve my medical records in my absence. Without their names on this list *Gulf Imaging Open MRI* WILL NOT be allowed to release any information.

Name _____ Name _____