

Lincoln Trail Diagnostics	Exam Date and Time:	MRN/Jacket:	Patient Registration
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Name: _____
Address: _____ City, State, Zip: _____
Home Phone: _____ Mobile Phone: _____
Email: _____ Date of Birth: _____
Race: _____ Gender: _____ Marital Status: _____
SSN: _____
Referring Physician: _____

Emergency Contact Information

Name: _____ Contact Phone: _____

Insurance

Primary Insurance Plan Name: _____
Policy #: _____ Group #: _____
Secondary Insurance Plan Name: _____
Policy #: _____ Group #: _____

Relationship to Insured

Insured Name: _____ Relationship to Patient: _____
Insured DOB: _____

Auto Accident or Worker's Compensation Information

Is this injury due to accident? Yes No If yes, what type of Accident? _____
Accident Date: _____ Accident State: _____

Patient Name:

MRN/Jacket #:

By signing below, I agree to the following for outpatient radiology care provided by Lincoln Trail Diagnostics

Authorization for Treatment

I hereby consent to and permit the attending physician and other medical staff to provide me treatment and care as may be deemed necessary and available to me during my office visit or outpatient procedure, including but not limited to tests, examinations, local anesthetics, x-rays and medical and surgical treatments, and other necessary procedures.

Release of Medical Information

With this consent, Lincoln Trail Diagnostics may use and disclose my protected health information for treatment, payment and health care operations as explained in the Lincoln Trail Diagnostics . Notice of Privacy Practices. I also authorize release of my protected health information to Lincoln Trail Diagnostics , the interpreting Radiologist group, government agencies (such as Medicare and Medicaid), insurance carriers, and other providers for treatment purposes. I understand that I may authorize a personal representative to have access to my protected health information as well.

Would you like to authorize a personal representative to have access to your protected health information including your images, films and reports, please list the person's name, DOB and relationship?

Yes No

MEDICAL RECORDS CAN BE RELEASED TO:

Name: _____ Date of Birth: _____ Relationship to Patient: _____

Financial Responsibility

With this consent, I authorize Lincoln Trail Diagnostics and/or their representatives to review my insurance coverage with my insurance company. I request that payment of authorized benefits be made directly to Lincoln Trail Diagnostics on my behalf. I fully understand that I am financially responsible for any and all amounts not otherwise paid by my insurance carrier or worker's compensation. I also certify the information, on this form, given by me for payment under Title XVIII (Medicare) is correct and complete.

Notice of Privacy Practices

I acknowledge that I had the opportunity to review the Notice of Privacy Practices. I understand I may request a paper or electronic copy of this policy to keep.

With this consent, Lincoln Trail Diagnostics may call or email my home or other alternative location and leave messages or voice mail in reference to any items that assist them in carrying out treatment, payment and health care operations, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including test results, among others.

I understand I may revoke my consent in writing except to the extent that Lincoln Trail Diagnostics has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it Lincoln Trail Diagnostics may decline to provide treatment to me.

Signature: _____

Date: _____

Printed Name: _____