TOWER RADIOLOGY

REGISTRATION FORM

Patient Information

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Work: _____ Cell: _____

Date of Birth: _____ Age: ____ Social Security Number: _____

Sex: □ Female □ Male Marital Status: □ Single □Married □ Divorced □ Widowed
Referring Physician: _____
Primary Physician: _____
Emergency Contact: _____ Phone: _____
How did you hear about us?_____
Email Address: _____

Responsible Party

Name: _____ Relationship to Patient: □ Self □ Spouse □ Parent
Phone Number: _____ Date of Birth: _____
Address: _____
City: _____ State: _____ Zip: _____

Insurance Information

Primary Insurance: _____Subscriber SSN: _____
Subscriber Name: _____Subscriber DOB: _____
ID Number: _____Group Number: _____

Secondary Insurance: _____Subscriber SSN: _____
Subscriber Name: _____Subscriber DOB: _____
ID Number: _____Group Number: _____

Auto Accident / Workers Compensation:

Date of Accident: _____ How did it happen: □ Auto □ Work
Insurance Company Name: _____ Claim #: _____
Address: _____
Adjuster's Name: _____ Phone #: _____

NATIONAL HARBOR
251 NATIONAL HARBOR BLVD SUITE 101
OXON HILL, MD 20745
301-638-4606 PHONE / 301-485-1185 FAX

FAIRVIEW CENTER
4255 ALTAMONT PLACE SUITE 102
WHITE PLAINS, MD 20695
301-638-4606 PHONE / 301-638-4608 FAX

PREVIOUS EXAMS RELATED TO YOUR VISIT TODAY:

Facility/Location:_____Phone:_____
Exam: _____ Date of service: _____

If your provider is requesting a comparison to a prior study, it is the PATIENT'S RESPONSIBILITY to obtain and supply Tower Radiology with the prior images.

RELEASE OF MEDICAL RECORDS

I authorize Tower Radiology, LLC to release my medical imaging records including my radiographs, professional interpretations, reports, and other medical information to the "Authorized Person" whose name appears below. I understand that anyone not listed below will not have access to medical information at Tower Radiology, LLC.

Name	Relation	DOB
1._____	_____	_____/_____/_____
2._____	_____	_____/_____/_____
3._____	_____	_____/_____/_____

X_____ _____/____/_____
Signature Date

X_____ _____/____/_____
Witness Date

FINANCIAL ARRANGEMENT:

I authorize Tower Radiology to release from my medical records any information required by my insurance carrier or any person, company, or agency responsible for processing my claims for medical services.

I authorize payment directly to Tower Radiology of all insurance or health plan benefits otherwise payable to me, to the extent of my bill. I acknowledge that I am financially responsible for charges not paid by my insurance or other agencies, and for co-pays, deductibles and/or coinsurance. If my account is placed with a third party in order to effect collection, I agree to be responsible for all costs of collection which may include but are not limited to: attorney fees, court costs, third party billing/credit reporting fees, collection agency fees including a 25% surcharge. (e.g. Suburban Credit Corporation), etc. I have read the notice of Privacy Practices in regards to HIPAA.

Signed: _____ Date: _____