

Kennestone Office
 598 Nancy Street, Suite 150
 Marietta, GA 30060
 Ph: (678)-581-3830
 Fax: (770)-794-4680

Quantum Radiology Patient Registration



Cobb Office
 1625 Hospital North Dr., Suite 150
 Austell, GA 30106
 Phone: (770)-944-0466
 Fax: (770)-941-0629

Patient's Legal Name- Last			First	MI	Also Known As: (maiden, nicknames, etc.)		
Street Address							Apt. #
City		State		Zip		Country	
Mailing Address (if different from above)							
Home Phone #			Cell Phone #			Pager #	
Soc. Sec. #		Driver's License #		State	Date of Birth		Marital Status
							Sex
Patient's Employment Status (circle one) Full-time Part-time Retired Not Employed							
Patient's Occupation				Employer			
Employer's Address				City		State	Zip Code
Address (continued)				Work Phone # (and extension)		May we call you at work? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Referring Physician (must have First and Last name)					Physician's Phone #		
Family or Primary Physician, if different from above (must have First and Last name)					Physician's Phone #		
Emergency Contact							
Name - Last			First			Relationship	
Daytime Phone #			Evening Phone #		Pager # / Cell Phone #		
Financial Information -- If you have insurance card(s) with you, you can omit this section							
Primary Insurance				Secondary Insurance			
Insurance Company Name				Insurance Company Name			
Insurance Company's Telephone #				Insurance Company's Telephone #			
Address to mail claim				Address to mail claim			
City		State		Zip		City	
Name of Insured / Relationship			Group #	Name of Insured / Relationship			Group #
Policy #				Policy #			
Beginning Coverage Date		HMO or PPO		Beginning Coverage Date		HMO or PPO	
What is your co-pay amount?				What is your co-pay amount?			

AUTHORIZATION TO CONTACT ME: I authorize Quantum Radiology to contact me, either by phone or by mail to provide a reminder of an appointment, and/or information about any new technology or services that Quantum Radiology will be offering. Yes No

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE: I hereby acknowledge that Quantum Radiology has provided me a copy of their Privacy Notice.

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY / ASSIGNMENT OF BENEFITS: The information above is accurate and true to the best of my knowledge. I authorize Quantum Radiology to file insurance claims on my behalf to Medicare or other insurance plans shown above. I understand that I am responsible for any deductible, co-payment, or non-covered service at the time that services are rendered. I authorize payment of any benefits due under my insurance plan to Quantum Radiology when insurance is filed on my behalf. I understand that I may be charged for missed office visits not canceled at least 48 hours in advance. I understand that it is my responsibility to understand the benefits of my insurance plan AND that I am financially responsible for any services not covered by my plan.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION:

I authorize Quantum Radiology to release any medical information pertaining to my diagnosis and treatment to 1) any requesting physician or medical facility providing my medical care; 2) my insurance plan, employer (if employer-funded plan), Medicare, or other payer/provider of medical benefits which may or will pay for part of my medical expenses. I understand that release of this information may be required in order to obtain payment for medical expenses. This authorization applies to all information regarding my care, which may include information otherwise privileged or confidential by law (including information related to psychiatric care, drug/alcohol abuse, and HIV/AIDS confidential information). I hereby release Quantum Radiology from any and all liabilities, which may arise from the release of the information described above. This authorization will remain in effect for ONE (1) YEAR from the date of my signature.

Patient Signature: _____

Date: _____