PATIENT REGISTRATION

Last	**First**	**MI**	Also Known As: (maiden, nicknames, etc.)		
Street Address			Apt. #		
City			State	Zip	
Mailing Address (if different from above)					
Home Phone #	Cell Phone #		E-mail		
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 ❑ No ❑		
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	
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 Northwest 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 Northwest 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 Northwest 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:** _____