



REGISTRATION FORM

PATIENT INFORMATION

Patient's Last Name		First	Middle	<input type="checkbox"/> Mr. <input type="checkbox"/> Miss <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.	Marital Status (Circle One) Single / Mar / Div / Sep / Widowed	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?	(Former Name)		Birth Date / /	Age	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Street Address		City	State	ZIP Code	Social Security	Home # () Cell # ()
P.O. Box		City	State		ZIP Code	
Email Address		Occupation	Employer		Employer Phone No.	

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD AND DRIVER'S LICENSE TO THE RECEPTIONIST)

Person Responsible for Bill		Birth Date / /	Address (if different)		Home Phone No. ()	
Occupation	Employer	Employer Address			Employer Phone No. ()	
Name of Primary Insurance		Subscriber's Name		Group #	Policy #	
Subscriber's S.S. #	Birth Date / /	Work Comp #	Date of Injury	Work comp contact	Contact info.	
Patient's Relationship to Subscriber		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other	
Name of Secondary Insurance (if applicable)		Subscriber's Name		Group #	Policy #	
Patient's Relationship to Subscriber		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other	

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)		Relationship to Patient	Home Phone No. ()	Work Phone No. ()
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Medicare Patient Agreement

Request that payment of authorized Medicare benefits be made either to me or on my behalf to Eclipse Imaging and Pain Management Center for any services furnished me by that provider. I authorize any holder of medical information about me to be released to the Center for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. This authorization is in effect until I choose to revoke it in writing.

Assignment of Benefits/Medical Release/Consent for Treatment/Acknowledgement of Notice of Privacy Policy

With this form I acknowledge I have the right to review and request a copy of the NOTICE OF PRIVACY from Eclipse Imaging and Pain Management Center and I authorize the release and disclosure of portions of my medical record necessary to obtain reimbursement for myself and/or for my covered dependents. This authorization gives Eclipse Imaging and Pain Management Center the right to request and receive medical information from other health care entities and providers to include but not limited to copies of lab results, diagnostic test reports, films/images, and other clinical information deemed necessary by Eclipse Imaging and Pain Management Center, physicians or representatives. I understand I am not required to sign this authorization as a condition of my treatment, unless permitted by law. I also understand that I may inspect my protected health information, request more information, and revoke this authorization, as permitted by the federal privacy regulations and in accordance with Eclipse Imaging and Pain Management Center privacy policy. I hereby consent to any medical treatment, x-ray, laboratory or other procedure, which the physician(s) may consider or advise in treatment of my case (or as legal guardian for patient). I hereby authorize any benefits due to be paid directly to Eclipse Imaging and Pain Management Center 5750 Rufe Snow Dr. Ste 108 North Richland Hills, Texas 76180. This agreement will remain in effect until I choose to revoke it in writing. I understand that I am seeing Eclipse Imaging and Pain Management Center and, as a courtesy, the office will be billing my insurance company. However, I so understand that should my insurance company send the payment to me, I will forward the payment within 48 hours to Eclipse Imaging and Pain Management Center. I also understand that should I not send the payment to the office and the office has to proceed with the collection process; I will be responsible for any cost incurred by the office to retrieve their moneys. I also understand that the office may have to report said payment to the Internal Revenue Service as income. I hereby authorize my insurance company to pay my benefits directly to Eclipse Imaging and Pain Management Center and I understand that I will be fully responsible for any outstanding balance on my account. The information that I have provided to Eclipse Imaging and Pain Management Center is true and correct in its entirety.

Payment

Payment for your deductible, co-pay and/or coinsurance is due and payable at the time of service, unless prior arrangements have been made. The patient or responsible party also agrees to pay for any services not covered by the patient's or guarantor's insurance or health plan.

Film Retention Policy

I understand that Eclipse Imaging and Pain Management Center maintains my films electronically and I must give a 24-48 hour notice if I need my films printed. Any requests for films less than 24 hour notice will be put on a CD. If additional copies of films are requested, a fee may apply.

X

Date

Relationship to Patient