PATIENT REGISTRATION FORM (IF THIS FORM IS NOT COMPLETE, WE CAN NOT BILL YOUR INSURANCE)

LEGAL NAME (Please PRINT legibly) Have you been here before? Yes No

Patient Name:		**Date of Birth:**	**Male or Female**
Address:		**City/St/Zip:**	
Cell:	Home:	Work:	**Preferred method of contact:** Cell Home Work
Social Security #:		Relationship Status: S M D W	
Employer:		Phone:	
Emergency Contact:		Phone:	Relationship:
Referring Physician:		Primary Physician:	

How did you hear about us? _____

Email address: _____ Would you like to receive an email w/ a secure link to view your results? YES NO

If you mark yes you will receive an email from tcr@ramsoftpacs.com within a few days of your exam. The first email will provide you with instructions on signing up for a Microsoft HealthVault account, allowing you to login and view your reports securely. Email is not a secure method of transferring patient data (we apologize for the inconvenience). If you would like to receive an electronic copy of your results via an unencrypted email please initial here: _____

Who will be responsible for your account? Self Spouse Father Mother Other _____

Name: _____ Date of Birth (required): _____ Phone: ( ) _____

Address (if different than yours): _____ City/St/Zip: _____

Primary Insurance: _____ Policy #: _____	Subscriber's Name: _____ Date of birth: _____ Relationship to patient: _____	**Labor & Industries Claim** (ALL Required Info): Claim #: _____ Date of Injury: _____ Employer for L&I Claim: _____ Employer phone: _____
Secondary Insurance: _____ Policy #: _____	Subscriber's Name: _____ Date of birth: _____ Relationship to patient: _____	

Work Related? YES NO	Is an attorney involved? YES NO
Auto Accident? YES NO	Attorney Name: _____
Injury Date (required): _____	Phone: ( ) _____

As part of the nationwide initiative to improve the health of our nation, we are required to collect the following information for compliance with current Guidelines. If you have questions please visit ONC for Health Information Technology at www.healthit.hhs.gov and search 'meaningful use.' Please circle one:

Race	American Indian or Alaska Native	Other Pacific Islander	Asian	Refuse to Answer
	Black or African American	Native Hawaiian	White	More than one race
Ethnicity	Hispanic or Latino	Not Hispanic or Latino	Undefined	Refuse to Answer
Preferred Language	English Spanish	Vietnamese	Hindi	Refuse to Answer
Smoking Status	Current every day smoker	Current some day smoker	Former smoker	
	Never Smoker	Smoker, status unknown	Unknown if ever smoked	

Assignment & Release: I authorize release of any information for Tri-City Radiology claims. I acknowledge full responsibility for the payment of services rendered and agree I will take responsibility for any and all costs incurred by my failure to remit for services rendered. The above information is complete and accurate to the best of my knowledge. I acknowledge that I have been informed of my privacy rights regarding my health information. **I understand that it is my responsibility to know my insurance coverage and when a prior authorization is required. I assume liability for all non-covered charges and deductibles.** I consent to be contacted by regular mail or on my cell phone regarding any matter related to the above referenced account by the creditor, its successors or assigns. This consent includes any updated or additional contact information that I may provide and included phone calls that employs auto-dialer technology and prerecorded messages. This consent shall apply to all current accounts I have with Tri-City Radiology, including accounts that have been assigned to a third-party collection agency. If I wish to revoke consent to call my cell phone, I agree to provide you notice of that revocation by emailing you at kimiz@tricityradiology.com or mailing it to 7221 W Deschutes Ave, Suite A, Kennewick, WA 99336.

Signature: _____ Date: _____