Patient Registration Form

Patient Name: ____

Mailing Address: ______________________________ City: ________________ State: _____ Zip: _________

Home Phone: ____________________________ Cell Phone: ____________________________

Birth Date: ____________________ SSN: ____________________ Male: _________ Female: _________

Employer: ____________________________________ Work Phone: ________________________

Emergency Contact: ____________________________ Emergency Contact Phone: ________________

Insurance Policy Holder Name: ________________________ Policy Holder Date of Birth: ________________

Payment Policy & Benefits Estimation

Financial Assistance/Payment Plans: 1-877-295-2147

TO OUR PATIENTS: To help answer questions you might have, we have outlined our payment policies below. Please feel free to discuss these with us at anytime, should you have additional questions.

Payment Policy: Accounts are payable after your insurance carrier has paid your claim, or within 30 days of your first statement. Self-pay patients will be asked to pay in full at the time of service. Payment arrangements can be made if necessary on the remaining balance. We accept all forms of payment. Past due accounts will be turned over to a collection agency if the account is not paid in full within 90 days from the date of your first statement. You may make payments online (www.touchstoneimaging.com) or through our automated phone system using a credit card. If you require financial assistance or a payment plan, contact information is above.

Benefits Estimation: If we are filing with your insurance, please keep in mind we make every effort to collect only the portion you owe at the time of service. However, this is only an estimate, and often you may have a remaining portion to pay as a copay, co-insurance or deductible. Your insurance plan will send you an "explanation of benefits" which will explain how your claim was processed. You will receive a statement of any balance you owe after we receive payment from your insurance company. As a service to you we endeavor to provide the most accurate information regarding network participation (I.e.) in-network vs. Out-of-network) and cost to you as a patient. However, these are estimations based on information available from your insurance carrier and subject to change given your insurance's final deliberation of this claim. It is your responsibility to verify the network participation of our facilities with your particular insurance plan as well as the patient benefits you receive at our facilities. Should your insurance deny your claim for reasons beyond our control, you assume responsibility for payment of the claim.

Assignment of Benefits & Authorization to Pay:

Assignment of Benefits: I Authorize Touchstone Medical Imaging to release any medical or other information necessary to process my claims for services rendered to me or my dependent.

Authorization to Pay: I authorize payment of medical benefits to the physician or supplier for services rendered to me or my dependent in connection with imaging studies performed by Touchstone Medical Imaging.

Payment Procedures and the TCPA Act:

I authorize Touchstone Medical Imaging, its assignees, and third party agents to utilize all contact information I have provided to communicate with me. This includes, but is not limited to, home telephone, cellular telephone, and email/text communications. I hereby grant permission and consent to Touchstone Medical Imaging, its assignees, and third party agents to place calls to my home telephone, cellular telephone, and employment telephone; leave messages (whether voice or text); and utilize pre-recorded/artificial voice messages and/or automatic dialing devices in connection with any communication to me.

Patient/Legal Guardian Signature: ______________________________ Date: ________________