Patient Registration Form

PLEASE PRINT YOUR INFORMATION AND COMPLETE IN ENTIRETY

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: _____________________

Patient Billing Policy

Payment Policy & Benefits Estimation

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 any time, 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. We accept all forms of payment. Please note: 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 at (www.touchstoneimaging.com. If you require financial assistance or a payment plan, please call 1-877-275-9077. Touchstone may apply payments received to any outstanding balance. Patients will be financial responsible for any return check fee's that Touchstone incurs.

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 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" (EOB) which explains how your claim was processed. You will receive a statement of any balance you owe after we receive payment from your insurance(s). 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 our 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 insurance carrier 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 for the claim.

I have read and understand the above-referenced policy and benefits estimation. Initial:__________

Assignment of Benefits & Authorization to Pay

Assignment of Benefits:

I, the undersigned, hereby authorize Touchstone Medical Imaging to release any medical or other information necessary to process my claims for services rendered to me or my dependent. Initial:__________

Authorization to Pay:

I, the undersigned, hereby 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. Initial:__________

Collection Procedures and the TCPA Act:

I authorize Touchstone Medical Imaging, its assignees, and third party collection agents to utilize all contact information I have provided to communicate with me. This includes, but is not limited to, home telephone, cellular telephone, employment telephone, and email/text communications. I hereby grant permission and consent to Touchstone Medical Imaging, its assignees, and third party collection 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. Information will only be supplied to Touchstone Medical assignees and third-party collection in order to collect on outstanding balances. Initial:__________

By signing below, I hereby acknowledge that I have read, understand, and consent to all policies set forth herein.

Date: __________ Patient/Guardian Signature: ______________________________

REV 3.11.19

Touchstone
MEDICAL IMAGING

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of Touchstone Medical Imaging's Notice of Privacy Practices currently in effect.

Name (Please print) ____

Signature ____

Date____________ Relationship to Patient: ☐ Self ☐ Personal Representative ☐ Other: _______

PATIENT CONSENT

Touchstone may discuss my medical information/condition with: ***(List each Name/Relationship to patient)***

Name:____ **Relationship:**______________

Name:____ **Relationship:**______________

Name: ____ **Relationship:** ______________

***I understand it is my responsibility to notify Touchstone of any changes to this consent. ***

______________________________ ______________________________ __________________

(PRINT NAME PLEASE) **(SIGNATURE)** **(DATE)**

ONLY CHECK THE FOLLOWING BOX AND PRINT YOUR NAME TO OPT-OUT OF CORHIO

CORHIO (The Colorado Regional Health Information Organization) is a nonprofit organization dedicated to improving health care in Colorado. CORHIO provides a protected electronic system that allows doctors, hospitals, and other medical professionals to store and share records. CORHIO's vision is to provide a method to share health information so that every person in Colorado can obtain the best possible health care, where and whenever they need it.

☐ I,____, have chosen to **opt-out** of the participation in the Colorado Regional Health Information Organization (CORHIO) HIE. I have signed the CORHIO opt-out form, and if I chose later to opt back in, I will be required to sign the opt-inform.

FOR OFFICE USE ONLY

Notice of Privacy Practices currently in effect given to individual on today's date.
☐ In Person ☐ Mailing ☐ Email ☐ Other ______________________

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ☐ Individual refused to sign (did not want to, no reason provided, etc.)
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Did not respond after more than one attempt
- ☐ Other (Please Specify) ____

The following good faith efforts were made to obtain the individual or parent/legal guardian's signature. Please document with dates, times, individuals spoken to, and outcome, the efforts that were made to obtain the signature.

- ☐ In person conversation ______________________________________
- ☐ Telephone contact ______________________________________
- ☐ Mailing ______________________________________
- ☐ Email ______________________________________
- ☐ Other ______________________________________