



PATIENT REGISTRATION AUTHORIZATION/CONSENT FORM

Name: _____ DOB: _____

Address: _____

Email: _____ Phone: _____

As used in this form, the words “I,” “me,” and “my” mean the patient whose name appears above, or the parent, legal guardian or other legally authorized person on behalf of the patient named above.

General Consent for Radiology Testing, Procedures and Services

I hereby authorize **Atlantic Medical Imaging (AMI)** and all providers and ancillary personnel of AMI to perform or provide radiology testing, procedures and services to me as ordered by my physician or other medical provider. I understand that certain radiology tests, procedures and services will require an additional specific written informed consent, and that AMI will provide me with information and forms prior to any such tests, procedures or services. I also authorize and consent to the taking of photographs, video or other images of me and/or parts of my body for purposes of identification, diagnosis, treatment, payment and healthcare operations of AMI. Any photographs, video or other images will become part of my health record at AMI. AMI will not use such photographs, video or images for any other purpose without my specific written consent. I am aware that the practice of medicine and radiology is not an exact science and I acknowledge that no guarantees have been made to me as to results of any testing, procedures or services I receive at AMI.

Acknowledgement of Receipt of Notice of Privacy Practices

I have received a copy of AMI’s Notice of Privacy Practices, which contains information on AMI’s uses and disclosures of my health information. I understand that AMI has the right to change its Notice of Privacy Practices from time to time and that whenever an important change is made, AMI will post a new notice in its offices. I may contact AMI at any time to obtain a current copy of AMI’s Notice of Privacy Practices. I also may access a copy on AMI’s website.

Consent To Use and Disclose Health Information for Treatment, Payment and Health Care Operations

I hereby consent and authorize AMI to use and disclose my health information, which includes all or any part of my health and billing records, by and to AMI’s workforce members and to health care professionals, insurance companies, medical facilities, physicians, vendors, suppliers and others involved, or who may become involved, with my care and treatment, the payment for my care and treatment and/or the health care operations of AMI. I understand that, for example, my health information may be used or disclosed by AMI to: provide for my care and treatment; communicate among various health care professionals who are or will be involved in my care or treatment, whether or not such professionals are affiliated with AMI; bill for and obtain payment for care and treatment provided by AMI; provide information to and obtain payment from my health insurance company or plan; assess and review the quality of my care; discuss my care or payment for my care with family and friends involved in my care or payment for my care; and conduct AMI’s business and health care operations. In addition, I understand AMI may release my health information as required by law or court order.

Advance Directive

I understand that I have the right to complete and sign an advance directive. I understand that if I have an advance directive, it is my responsibility to provide a copy of my advance directive to AMI staff on the day of service. As an ambulatory health care facility, AMI will not honor any instruction in an advance directive instructing health care providers to withhold or otherwise not initiate or continue resuscitative efforts if the need arises. All efforts will be made to resuscitate patients for transfer to an acute care facility, at which facility any instructions concerning withholding or withdrawing of resuscitative efforts may be honored.

Acknowledgment of Financial Responsibility and Payment Guaranty

I understand that, if I am a Medicare or Medicare managed care recipient or am insured under any other commercial or governmental insurance plan that AMI accepts and is in par with, I am responsible for any deductible, copayment and coinsurance responsibilities required by Medicare or other insurer rules, as well as for any non-covered services. I also agree to pay all costs and expenses associated with any legal collection action, including but not limited to collection agency fees, attorney fees and court costs, for amounts owed by me. I authorize AMI or any authorized representative or business associate of AMI to contact me via telephone, cell/mobile phone, or electronic mail owned or used by me or my responsible party for debt collection purposes.

Consent to Obtain Prior Radiology Films, CDs, and Reports

Atlantic Medical Imaging will request the release of protected health information solely for the treatment and continuity of care purposes under the Health Insurance Portability and Accountability Act of 1996[45 CFR 164-506], as amended ("HIPAA"). This authorization will remain in effect unless revoked by the patient.

Consent and Authorization

I have read and understand the terms of this document. I have had an opportunity to ask questions about the use or disclosure of my health information and about the contents of this form. I acknowledge, consent and agree to the terms and conditions of this document:

Signature of Patient/Authorized Individual: _____

Patient/Authorized Individual Printed Name: _____

Authorized Individual Authority (e.g., Parent or Guardian): _____

Date: _____