SOUTHEASTERN
CONNECTICUT IMAGING CENTER
AN OCEAN RADIOLOGY ASSOCIATES / L & M SYSTEMS PARTNERSHIP

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PATIENT REGISTRATION FORM

Name ______________________ Date of Birth ______________________ Sex M ______ F ______

Address ____

City ______________________ State ______________ Zip ______________

Home Phone# ______________ Work Phone # ______________ Social Security Number ______________

Emergency Contact ______________ Phone ______________ Relationship ______________

Employer Name & Address ____

Person responsible for bill ____

Primary Insurance ______________________ Secondary Insurance ______________________

ID/Group# ______________________ ID/Group# ______________________

Guarantor ______________________ Guarantor ______________________

Relationship to patient ____

Referring physician ______________________ Phone Number ______________

The following may access my account information: ______________ Relationship ______________

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RELEASE OF INFORMATION, BENEFIT ASSIGNMENT, PAYMENT AUTHORIZATION, FULL DISCLOSURE STATEMENT AND AGREEMENT TO PAY FOR SERVICES

I hereby authorize SCIC to release any information requested by the insurance company, in order to process this claim. I hereby authorize payment directly to SCIC in making this authorization; I understand that I may be billed for any unpaid balance **not** covered by my insurance.

I hereby authorize SCIC to release any information necessary to process my insurance / Medicare claim, acquired in the course of my examination or treatment; to allow a photocopy of my signature to be used to process my insurance / Medicare claim for the period of lifetime. I claim any insurance benefits due me for services rendered by SCIC and authorize and direct my carrier to issue payment / check(s) directly to SCIC. Regardless of my insurance benefits, if any, I understand that I am fully financially responsible for any and all fees/co-pays incurred, and I agree to pay such fees in full.

The insurance information furnished represents a full disclosure of the insurance / third party benefits to which I am entitled. I understand that failure to disclose pre-certification / second opinion requirements for any and all plans to which I subscribe, may cause me to incur full liability for professional charges, as a result of non-payment by any carrier.

____ ______________________

Patient / Responsible Party Signature **Date**

____ ______________________

Witness Signature **Date**