



Registration Form

PATIENT INFORMATION

Patient Last Name, Jacket #, Social Security #, Address, City, State, ZIP, Employer Name, Job Title, Employer Address, Employer City, State, ZIP, Work Phone, Emergency Contact Person (not living with you), Name, Phone, Address

RESPONSIBLE PARTY INFORMATION

Name, Address, Relationship, SSN, DOB, Employer, Phone, Address

INSURANCE INFORMATION

On the Job Injury?, Motor Vehicle Accident?, Primary Carrier, Address, City, State, ZIP, Phone, Policy Holder, Relationship, Policy #, DOB, Group #, Gender, Address, City, State, ZIP, Effective Date, Expires, Copay, Authorization, Adjuster, Secondary Carrier, Address, City, State, ZIP, Phone, Policy Holder, Relationship, Policy #, DOB, Group #, Gender, Address, City, State, ZIP, Effective Date, Expires, Copay

RELEASE OF INFORMATION AND PAYMENT AUTHORIZATION

I authorize the release of information necessary to process this claim and assign benefits payable for services directly to Envision Imaging of Frisco. I authorize the release of any medical information necessary for treatment by my current or future physician or health care provider. I authorize Envision Imaging of Frisco to release to my insurance company any medical information which may be necessary to process my insurance claim. I understand that in the event my insurance company denies this claim, I will be held financially responsible for all charges.

I acknowledge that I have received a copy of Envision Imaging of Frisco's Privacy Notice. Initials: _____

Printed Name _____

Signed _____ Date _____