Maximum Resolution Imaging
THE NEW ERA OF IMAGING
www.maxresolutionimaging.com

PATIENT REGISTRATION FORM

5530 Long Prairie Trace
Suite 400, Richmond
Texas 77407
Phone: (832) 400–2731

Date:_____ **Referring Physician:**_____

Patient Information:

Last Name:_____ **First Name:**_____ **Middle Initial:** ____

Sex:_____ **Date of Birth:**_____ **Address:**_____ **Apt #:**_____

City:_____ **State:**_____ **Zip Code:**_____ **Cell #:**_____ - _____ - _____

Is Patient a Minor? Yes /No if yes, parent/guardian name: _____

Emergency Contact:

Name:_____ **Relationship to patient:** _____

Street Address:_____ **City:**_____ **State:**_____ **Zip Code:** _____

Cell Phone #:_____-_____-_____ **Work Phone #:**_____-_____-_____

Insurance Information:

Primary Insurance:

Insurance Name: _____

Policy #: _____

Group #: _____

Insured Name: _____

DOB:_____

Relationship to the patient: _____

Secondary Insurance:

Insurance Name: _____

Policy #: _____

Group #: _____

Insured Name: _____

DOB:_____

Relationship to the patient: _____

Consent and Acknowledgement

I authorize Maximum Resolution Imaging to release any necessary medical or other information for this or related claim. If accepted, I request direct payment of insurance benefits to Maximum Resolution Imaging. I am responsible for the deductible, co-payment and non-covered services as determined by my issuer.

I understand that any deductible or co-insurance payments made on this exam date are estimates based on information that Maximum Resolution Imaging has received from my insurance company prior to claim submission. Additional amounts may be my responsibility according to my individual insurance plan, and Maximum Resolution Imaging will bill me for any remaining balance.

I authorize the release of information, films, and copies relevant to my medical history follow-up of any suspicious findings. This consent authorizes Maximum Resolution Imaging to release my medical records, including images and reports, to my insurance company, referring physician, and other physicians involved in my care.

Yourself, or others having written permission, will be required to present a photo I.D. when picking up medical records. PLEASE ALLOW 24 HOURS FOR PROCESSING YOUR IMAGES AND RECORDS PRIOR TO PICKING THEM UP.

As a Maximum Resolution Imaging patient, I acknowledge reviewing Maximum Resolution's Notice of Privacy Practices as required by HIPPA. I understand that I can request a paper copy of this policy for my records.

Signature of Patient/Parent/Guardian: _____ **Date:** _____