Summit Imaging
12037 Cortez Boulevard
Brooksville, Florida 34613
(352) 597-9008 • Fax: (352) 597-1008

PATIENT REGISTRATION FORM

Patient's Name: Last: _____ First: _____ Middle: _____

Social Security #: _____ Male ❑ or Female ❑ Date of Birth: _____

Address: _____ City/State/Zip: _____

Phone: _____ Cell: _____ Work: _____

Retired: Yes ❑ or No ❑ Employer: _____ Phone: _____

Doctor Requesting Exam: _____ Other Doctor to Receive Report: _____

Primary Insurancy Company: _____ Phone: _____

Policyholder's Name: _____ Date of Birth: _____

Relationship: _____ Ins. ID #: _____

Secondary Insurance Compay: _____ Phone: _____

Policyholder's Name: _____ Date of Birth: _____

Relationship: _____ Ins. ID #: _____

Acknowledgement and Assignment of Benefits: I hereby acknowledge that I have received medical services from Summit Imaging. In consideration of the services and treatment rendered, I hereby authorize and direct payment of medical benefits to Summit Imaging and assign and all causes of action that I may have against any insurance company (including all coverages for PIP and/or Med-pay, as a result of a vehicular accident), obligated to me by law, statute, or contractual agreement, for payment for such medical services and treatment. I direct my insurer to escrow any personal injury protection and / medical payments benefits it disputed for services or treatments rendered to me by Summit Imaging. I also understand that the medical services rendered by Summit Imaging could have been obtained by other providers but chose to obtain said services and treatment from said facility. I also authorize the release of any pertinent information or medical records to Summit Imaging and any other medical provider, insurance company or attorney involved with my medical treatment or case and/or litigation, that is seeking to obtain payment for medical services and treatment rendered by Summit Imaging, and others on its behalf. I hereby direct my insurance carrier to provide a copy of the PIP log or benefit payout sheet as well as any written explanation as to payments or reductions made or denied or other correspondence pertaining to a claim for services or treatment rendered to me as specified herein. A photocopy of this assignment shall be considered as valid and effective as the original.

I hereby acknowledge that Summit Imaging and employees do not assume responsibility for securing valuables or personal items belonging to patients or visitors. Although lockers may be available, they are intended only as a convenience and should not be considered secure.

I have read the above statement and understand that I am fully responsible for securing my valuable or personal items. I further acknoweldge that this facility and its employees are not liable for the loss or theft of these items.

I agree that the information supplied on this form are accurate and up to date to the best of my knowledge.

Signature of Patient or Representative: _____ **Date:** _____