



HUNTINGTON-HILL
IMAGING CENTER INC.
PLEASE PRINT

Account Number:

PATIENT										
LAST NAME			FIRST			MI	HOME PHONE			
STREET					CITY			STATE	ZIP CODE	
BIRTHDATE		AGE	SEX	SOC.SEC.NO.		REFERRING DOCTOR			PATIENT STATUS <input type="checkbox"/> NEW <input type="checkbox"/> RETURNING	
EMPLOYER					OCCUPATION			DATE OF HIRE		
EMPLOYER ADDRESS			CITY			STATE	ZIP CODE	WORK PHONE		
REASON FOR VISIT <input type="checkbox"/> SICKNESS <input type="checkbox"/> INJURY		INJURY/ACCIDENT CAUSED BY <input type="checkbox"/> PERSONAL <input type="checkbox"/> AUTO <input type="checkbox"/> WORK			*PATIENT E MAIL* (see below)					
RESPONSIBLE PARTY										
LAST NAME		FIRST		MI	STREET					
CITY		STATE	ZIP CODE	HOME PHONE		BIRTHDATE	RELATIONSHIP TO PATIENT			
EMPLOYER				OCCUPATION			LENGTH OF EMPLOYMENT			
EMPLOYER ADDRESS					WORK PHONE		SOC. SEC. NO.			
CONSENT TO TREATMENT AND AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION										
<p>I consent to and authorize the administration of all diagnostic and therapeutic treatments by The Hill Medical Corporation ("Hill") radiologists that may be considered advisable or necessary in the judgement of the attending radiologist. I have been offered a copy of The Hill Medical Corporation's Notice of Privacy Practices. I authorize Hill to furnish my insurance carrier(s) information regarding my history, physical findings and treatment rendered.</p>										
SIGNATURE				DATE			WITNESS			
X										
AUTHORIZATION TO PAY BENEFITS AND ACCEPTANCE OF PAYMENT RESPONSIBILITY										
<p>I authorize payment of benefits directly to the provider for the services rendered. In addition, in the event that my insurance carrier(s) refuse payment for services rendered, I agree that I will be held financially responsible for payment.</p>										
SIGNATURE				DATE			WITNESS			
X										
EMERGENCY CONTACT										
NAME			RELATIONSHIP TO PATIENT		HOME PHONE		WORK PHONE			
PRIOR FILM AND REPORT RELEASE										
<p>To Whom it May Concern: I Authorize the release of my _____ films and reports in addition to any Surgical Pathology reports pertaining to my past medical history to: Huntington-Hill Imaging Center 625 So. Fair Oaks Suite #180 Pasadena, CA 91105 Attention: File Room Thank you for your cooperation,</p>										
X _____				Date: _____						
<p>This form is only used to obtain information from outside facilities for our Doctor's use. This release expires 1 year from the date it is signed.</p>										

*** E Mail Address for patient satisfaction survey use only and will not be shared.**