

Palmetto Ultrasound Centers Patient Registration Form | 2022

Patient Last Name: _____ MI: _____ First Name: _____ Birth Date: _____
Social Security Number: _____ Age: _____ Home Phone: _____
Female Work Phone: _____
Male Cell Phone: _____
Address: _____ City: _____ State: _____ Zip Code: _____

IN CASE OF EMERGENCY

Friend or relative: _____ Relationship to patient: _____ Contact number: _____

The above information is true to the best of my knowledge. I authorize my medicaid/medicare benefits be paid directly to the ultrasound center. I understand that I am financially responsible for any balance. I also authorize SonoCare, LLC or medicaid/medicare insurance company to release my information required to process my claims.

Patient/Guardian Signature

Date

If you need your images and are unable to pick them up, you authorize the release of records to the individual(s) listed below:

Email: For OB Pictures: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Your results will automatically be sent to your doctor

This authorization provides that:

- I may revoke this authorization at any time, provided that the revocation is in writing to the Privacy Officer at this practice, except if this practice has taken action relying on this consent or if the authorization was obtained as a condition of obtaining insurance coverage.
- I have the right to access my protected health information to be used or disclosed.
- I have the right to receive a copy of this completed and signed authorization form.

Patient/Guardian Signature

Relationship to the patient (if signed by a representative of the patient)

Date