

 **RETURNING PATIENT REGISTRATION FORM**

**PATIENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SEX: \_\_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_**

**STREET ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CITY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ STATE: \_\_\_\_\_\_\_\_\_\_\_\_ ZIP CODE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PHONE NUMBER (HOME): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CELL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**IS THIS VISIT RELATED TO A MOTOR VEHICLE ACCIDENT OR A SLIP/FALL? YES NO**

**CONSENT TO PERFORM DIAGNOSTIC TESTING:** I hereby authorize Hollywood Diagnostics Center to perform diagnostic testing on myself or my minor/dependent.

**RELEASE OF MEDICAL INFORMATION:** I hereby authorize Hollywood Diagnostics Center to release information from my patient medical records. This authorization, or photocopy thereof, will authorize the release of full and complete medical records when necessary to authorized healthcare providers, hospitals, and/or insurance companies. I understand that I may revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person(s) and/or organization(s) involved in my care have already acted in reliance on my authorization. I have read and understand the contents of this authorization and confirm that they are consistent with my direction.

**ASSIGNMENT OF CLAIM AUTHORIZATION:** I hereby authorize the direct payment of medical benefits to Hollywood Diagnostics Center. This authorization, or photocopy thereof, will authorize direct payment of medical benefits to Hollywood Diagnostics Center. I understand that I am financially responsible for charges not covered by this authorization.

**RECEIPT OF NOTICE OF PRIVACY PRACTICES:** A copy of the “Notice of Privacy Practices” has been made available to me for reading and/or copy, as well as being posted for my viewing from Hollywood Diagnostics Center concerning how the use or disclosure of protected health information will be handled by the our center. A personal copy can be made if requested.

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**PATIENT NAME (Please print) DATE**

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**SIGNATURE OF PATIENT/PARENT/LEGAL GUARDIAN**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**RELATIONSHIP TO PATIENT (Please print)**