BACK BAY IMAGING

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fax (949) 799-4000
info@backbayimaging.com

Patient Information

Name _____ **Phone** _____

Date of Birth _____ **Age** _____ **SSN** _____-_____-_____

Street Address _____

City _____ **State** _____ **Zip** _____

Employer _____ **Work Phone** _____

Employer Address _____

Referring Physician _____ **Injury Date** _____

Primary Insurance Company _____ **ID#** _____

Insurance Phone _____

Secondary Insurance Company _____ **ID#** _____

Attorney Name (If applicable) _____ **Phone** _____

I hereby authorize Back Bay Imaging to furnish my insurance company with information they may request concerning my medical condition. In addition, I authorize my insurance company to make payments directly to Focus Medical Imaging DBA Back Bay Imaging for medical expenses otherwise payable to me for the period of my treatment. I understand that I am financially responsible for charges not covered by my insurance policy.

_____ _____
SIGNATURE* DATE

Patient Consent Form to Use and Disclose Protected Health Information

By signing this form, you are granting consent Back Bay Imaging to use and disclose your protected health information for the purposes of treatment, payment and health care operations. Our "Notice of Privacy Practices" provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our "Notice of Privacy Practices" before you sign this consent, and we encourage you to read it in full.

Our "Notice of Privacy Practices" is subject to change. If we change our notice, you may obtain a copy of the revised notice by calling our facility at (949) 799-3000. You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement. You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

_____ _____
SIGNATURE* DATE

*Patient or Patient Representative: Parent/Conservator/Guardian