RADIOLOGY
of Greater New Haven

New Patient Registration Form

Radiology of Greater New Haven
1952 Whitney Avenue, 3rd Floor
Hamden, CT 06517
p. (203) 848-1708 | f. (203) 848-1777

Patient Information

First Name | Last Name | Sex | Date of Birth | Marital Status

Street Address | City, State, Zip Code | Social Security Number

Primary Phone ☐Home ☐Cell ☐Other | Secondary Phone ☐Home ☐Cell ☐Other | Email Address

Emergency Contact | Contact Phone/Address | Relationship to Patient

Financial Responsibility: Please enter information below for the Subscriber (insured). Check here if same as patient ☐

First Name | Last Name | Sex | Date of Birth | Marital Status

Street Address | City, State, Zip Code | Social Security Number

Primary Phone ☐Home ☐Cell ☐Other | Secondary Phone ☐Home ☐Cell ☐Other | Email Address

Relationship to Patient | Subscriber's Employer Name/Address | Employer Phone

Primary Insurance Information

Insurance Carrier | Insurance ID | Insurance Group No. | Carrier Address/Phone

Secondary Insurance Information

Insurance Carrier | Insurance ID | Insurance Group No. | Carrier Address/Phone

PLEASE NOTE: Some insurance plans require pre-certification and/or a physician referral in order to cover services such as diagnostic imaging. Please be sure to check with your plan and follow their guidelines of obtaining all appropriate referrals and pre-certifications prior to your appointment.

Patients who fail to obtain any of the documents required from their insurance plan risk having their study delayed or being denied benefits, rendering them responsible for payment.

Telephone Notification:
I authorize Radiology of Greater New haven staff to telephone my home for appointment notification, and to leave a voice message on a telephone answering machine or similar device, if I am not available.

Release of Information:
I authorize Radiology of Greater New Haven staff to release all pertinent information regarding treatment of the above named patient to all third parties for the purposes of claims processing.

Assignment of Insurance Benefits:
I authorize direct payment to Radiology of Greater New Haven all benefits payable to the provider who has rendered services for the above named patient.

Financial Agreement:
In consideration of the services rendered by Radiology of Greater New Haven, I agree to pay in full to the order of Radiology of Greater New Haven for all services rendered, including non-covered charges, deductibles, and co-payments, as well as no show fees, as applicable per the practice's policy, which is clearly posted. If it becomes necessary for Radiology of Greater New Haven to engage the services of an attorney or collection agency to collect balances due, I agree to pay lawful and reasonable attorney's fees, collection fees, and court costs.

_____

Signature Date