PATIENT INFORMATION

☐ **Huntington-Hill Imaging Center** Cordova
☐ **Huntington-Hill Imaging Center** Fair Oaks
☐ **Huntington-Hill Imaging Center** Glendora
☐ **Huntington-Hill Imaging Center** West Covina
☐ **Huntington-Hill Breast Center** Arcadia
☐ **Jim & Eleanor Randall Breast Center**

Account Number: ____________________

PATIENT

First Name	Last Name	Cell Phone*	Home Phone

Street Address	City, State, Zip

Date of Birth	Age	Sex	Soc. Sec. No.	Referring Doctor

Employer	Occupation	Date of Hire

Employer Address	City	State	Zip Code	Work Phone

Reason For Visit ☐ Sickness ☐ Injury	Injury/Accident Caused by ☐ Personal ☐ Auto ☐ Work	Patient email* (See Below)

RESPONSIBLE PARTY

Guarantor	Date of Birth	Home Phone
Guarantor Address		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

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 judgment of the attending radiologist. I authorize Hill to furnish to my insurance carrier(s) information regarding my history, physical findings and treatment rendered.

Signature ______________________ **Date** __________ **Witness** ______________

NOTICE OF PRIVACY PRACTICES

X _______ I have been offered a copy of The Hill Medical Corporation's Notice of Privacy Practices.
Patient's initials

AUTHORIZATION TO PAY BENEFITS AND ACCEPTANCE OF PAYMENT RESPONSIBILITY

I authorize payment of benefits directly to the provider of the services rendered. In addition, in the event that my insurance carrier(s) refuse payment for the services rendered, I agree that I will be held financially responsible for payment.

Signature ______________________ **Date** __________ **Witness** ______________

EMERGENCY CONTACT

Name ______________________ **Relationship to Patient** ______________

Home Phone ______________________ **Work Phone** ______________

PRIOR FILM AND REPORT RELEASE

To Whom it May Concern:

I authorize the release of my ______________________ films and reports in addition to Surgical Pathology reports pertaining to my past medical history to:

☐ Huntington-Hill Imaging Center - Fair Oaks
☐ Huntington-Hill Imaging Center - Cordova
☐ The Jim and Eleanor Randall Breast Center
☐ Huntington-Hill Imaging Center - Glendora
☐ Huntington-Hill Imaging Center - West Covina

▶ Please indicate the name of any additional physicians to receive a copy of the results:

____

____

Thank you for your cooperation,

X ______________________ Date ______________________

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.

*Email Address and Cell Phone will be used for patient communications only and will not be shared. Standard data/text rates may apply.