



Huntington-Hill Breast & Imaging Centers

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

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 <input type="checkbox"/> Sickness <input type="checkbox"/> Injury <input type="checkbox"/> Pre-op		Injury/Accident Caused by <input type="checkbox"/> Personal <input type="checkbox"/> Auto <input type="checkbox"/> 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	Cell 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 _____

NOTICE OF PRIVACY PRACTICES

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

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 _____

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 prior imaging films and reports, including surgical pathology reports, pertaining to my past medical history to the Medical Records Department of Huntington-Hill Breast and Imaging Centers for the purpose of continuity of care. I understand that this release applies to all locations of Huntington-Hill Breast and Imaging Centers and that my information will be securely maintained in the practice's centralized medical records system in compliance with HIPAA privacy regulations. This release expires one year from the date it is signed.

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

Thank you for your cooperation,

X _____ Date _____

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