The Radiology Clinic, LLC
Sign In

Name_____
Last First MI

Mailing Address _____

City_____ State _____ Zip _____

E-mail_____

Can we email you our monthly newsletter? ❒ Yes ❒ No

Date of Birth _____ Social Security # _____-_____-_____

_____ _____ _____
Primary Phone Secondary Phone Work Phone

Which should we call first? ❒ Primary ❒ Secondary ❒ Work

May we leave a voicemail or text message on your phone? ❒ Yes ❒ No

Date _____ Patient Signature _____

Insured's Place of Employment_____

Responsible Party (if other than patient)

Name_____
Last First MI

Mailing Address _____

City_____ State _____ Zip _____

Date of Birth _____

Acknowledgment of Receipt of Notice of Privacy Practices

By signing below, I acknowledge that I have received a copy of the Notice of Privacy Practices of The Radiology Clinic.

_____
Patient Name (Print)

_____ _____
Signature of Patient or Legal Representative Date