

RESPONSIBLE PARTY INFORMATION:

Last name First name Middle name

Patient Relationship to Responsible Party: _____

Sex: M F Date of Birth: ____/____/____ Social Security Number: ____ - ____ - ____

Address: _____ Apartment/Suite: _____

City: _____ State: _____ Zip Code: _____

Phone Number: Home: (____) ____ - ____ Work: (____) ____ - ____ Cell: (____) ____ - ____

Responsible Party Employer: _____

Referring Physician

Physician requesting today's exam: _____

Other physician(s) to receive report: _____

Are we billing Insurance for today's visit? Yes No

Primary Insurance (provide your insurance card to front desk)

Name of Policy Holder: _____ Patient's Relationship to Insured: _____

Policyholder Date of Birth: ____/____/____ Policyholder S.S.#: ____ - ____ - ____

Insurance Company Name: _____ Phone # : (____) ____ - ____

Insurance Company Address: _____

Policy #: _____ Group #: _____ Claim #: _____

Effective Date: ____/____/____ Accident or Injury Date: ____/____/____

Is this coverage through the policy holder's employment? Yes No

If yes, name of employer: _____

Is this an Auto Accident? Yes No

Is this a Worker's Compensation Claim? Yes No

Adjuster: _____ Phone #: (____) ____ - ____

****You must notify your auto insurance adjuster of your motor vehicle accident for the claim to be processed. Failure to do so makes you personally responsible for any charges.**

Is an attorney involved? Yes No

Attorney Name: _____ Phone #: (____) ____ - ____

Attorney Address: _____

Date:

Secondary Insurance (provide your insurance card to front desk)

Name of Policy Holder: _____ Patient's Relationship to Insured: _____

Policyholder Date of Birth: ____/____/____ Policyholder S.S.#: ____-____-____

Insurance Company Name: _____ Phone # : (____) ____-____

Insurance Company Address: _____

Policy #: _____ Group #: _____ Claim #: _____

Effective Date: ____/____/____ Accident or Injury Date: ____/____/____

Is this coverage through the policy holder's employment? Yes No

If yes, name of employer: _____

Acknowledgement of Assignment of Benefits

I hereby acknowledge that I have requested medical services from the above referenced facility. In consideration of the services and treatment rendered, I hereby authorize and direct payment of medical benefits to the above referenced facility and assign any and all causes of action that I may have against any insurance company (including all coverage for PIP and/or Med-pay, as a result of a vehicular accident), obligated to me by law, statute, or contractual agreement, for payment for such medical services and treatment. I direct my insurer to escrow any personal injury protection and/or medical payment benefits to disputes for services and treatments rendered to me by the above referenced facility. I also understand that the medical services rendered by the above referenced facility could have been obtained by other providers but chose to obtain said services and treatments from said facility. I also authorize the release of any pertinent information or medical records to the above referenced facility, and any other medical provider, insurance company or attorney involved with my medical treatment or case and/or litigation, that is seeking to obtain payment for medical services and treatment rendered by the above referenced facility or others on its behalf. I hereby direct my insurance company to provide a copy of the PIP log or benefit payout sheet as well as any written explanations as to payments or reductions made or denied or other correspondence pertaining to a claim for services or treatment rendered to me as specified herein. A photocopy of this assignment shall be considered as valid and effective as the original.

Signature of Patient or Personal Representative

Date

Authorization for Release of PIP or Med Pay Benefits

I hereby authorize my auto insurance carrier to release benefit information, related to the above referenced accident, to the above referenced facility.

Signature of Patient or Personal Representative

Date

Guarantee of Payment

I understand my financial responsibility and I guarantee payment for all charges not covered by my insurance, all applied deductibles and co-pays, within 30 days of receiving a statement. MEDICARE PATIENTS: I authorize the release of medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to the above referenced facility.

If the above referenced facility determines your account must be placed with a collector or an attorney for collection, the cost, including attorney fees, will be paid by the undersigned.

Patient Initial: _____

Notice of Privacy Practices

I, the undersigned, authorize the above center to use and disclose my information for the purposes of treatment, payment, and healthcare operations as described in the Notice of Privacy Practices. I acknowledge that I have been given the Notice of Privacy Practices. I understand that if I have questions or complaints I should contact the Privacy Official.

A photocopy of this consent shall be considered as valid as the original.

Patient Initial: _____

Valuables Statement

It is often necessary to remove valuables and personal items prior to undergoing an imaging exam. The above referenced facility and employees do not assume responsibility for securing valuables or personal items belonging to patients or visitors. Although lockers may be available, they are intended only as a convenience and should not be considered secure.

I have read the above statement and understand that I am fully responsible for securing my valuables or personal items. I further acknowledge that this facility and its employees are not liable for the loss or theft of these items.

Patient Initial: _____

I agree that the information supplied on these forms is accurate and up-to-date to the best of my knowledge.

Signature of Patient or Personal Representative

Date