

PATIENT INFORMATION (PLEASE PRINT)

LAST NAME		FIRST NAME		MI
DATE OF BIRTH / /	SS# / /	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female		
MAILING ADDRESS	APT #	CITY	STATE	ZIP CODE
HOME PHONE # () -	CELL PHONE # () -	WORK PHONE # () -		
CONTACT NAME		CONTACT PHONE # () -		
PATIENT EMPLOYER				
REFERRING PHYSICIAN				
EXPLAIN CURRENT SYMPTOM(S) FOR THIS EXAM(S)				

INSURANCE INFORMATION

1. PRIMARY INSURANCE: <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> MOTHER/FATHER <input type="checkbox"/> GUARDIAN		
Name:	DOB:	SS#
EMPLOYER:		
2. SECONDARY INSURANCE: <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> MOTHER/FATHER <input type="checkbox"/> GUARDIAN		
Name:	DOB:	SS#
EMPLOYER:		
3. WORKERS' COMPENSATION: YES – See attached Worksheet		

INSURANCE ASSIGNMENT

I hereby consent to the release of information to my insurance carrier regarding my treatment at Advanced Imaging Center. I further authorize payment to be made directly to Advanced Imaging Center for any insurance benefits to which I am entitled.

STATEMENT OF FINANCIAL RESPONSIBILITY

I understand and agree that, except as may be specifically limited to my health plan or health insurance, I am financially responsible for any and all charges for services rendered by Advanced Imaging Center regardless of the existence of a health plan or health insurance and assignment of insurance benefits.

RELEASE OF ADVANCED IMAGING MEDICAL RECORDS TO HEALTH CARE PROVIDERS

I hereby consent and authorize Advanced Imaging of Texarkana to release any and all information in my medical records to my physician(s) and other health care providers involved in providing care to me.

RELEASE OF MEDICAL RECORDS TO ADVANCED IMAGING

I hereby request and authorize my health care provider(s) to release to Advanced Imaging: medical records, x-ray films, reports and pathology results as needed in assisting Advanced Imaging in providing my medical consultation, care and/or treatment.

X _____
Signature of Patient/Legally Authorized Person /Financially Responsible Party

Date

PLEASE PRINT NAME

RELATIONSHIP

MEDICARE/MEDICAID – RADIOLOGY PROCEDURE ACKNOWLEDGEMENT OF POTENTIAL LIABILITY

Medicare/Medicaid will only pay for services that it determines to be “reasonable and necessary” under section 1862 (a)(1) of the Medicare or Medicaid Law. If Medicare/Medicaid determines that a particular service, although it would otherwise be covered is not “reasonable and necessary” under Medicare/Medicaid program standards, Medicare/Medicaid will deny payment for that service. Advanced Imaging believes that in your case, Medicare/Medicaid is likely to deny payment for: _____
_____ for the following reason(s) - Medical necessity based on diagnosis or condition:
_____.

I have been notified by my physician/supplier that he/she believes that, in my case, Medicare is likely to deny payment for the services identified above, for the reasons stated. If Medicare denies payment, I agree to be personally and fully responsible for payment.

Patient Signature Date

OUT OF NETWORK INSURANCE – ACKNOWLEDGEMENT OF POTENTIAL LIABILITY

I am aware that Advanced Imaging of Texarkana, where I am having services performed, is not considered to be “In Network” with the third party insurance plan that provides my payment coverage. I acknowledge that the insurance plan may, therefore, provide benefits at the “Out of Network” level. I understand that I am personally responsible for paying any remaining balance due for these services.

Patient Signature Date

Pregnancy Acknowledgment

Is there any possibility that you are now pregnant? Yes No

What was the start date of your last menstrual period? ____/____/____

Are you currently breastfeeding? Yes No

Patient/Guardian Signature Date

Witness Signature Date