

**RADIOLOGY IMAGING ASSOCIATES
PATIENT INFORMATION**

PATIENT NAME:			DOB:		
ADDRESS:			HOME #:		
CITY:	STATE:	ZIP:	SSN:		
EMPLOYER:			WORK: #:		
REFERRING PHYSICIAN:			REF PHONE #:		

EMERGENCY CONTACT

NAME	REL:	PHONE
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INSURANCE INFORMATION

~~PLEASE HAVE YOUR INSURANCE CARD READY FOR SCANNING~~

PRI INS:	POLICY#:	GROUP#:
NAME OF INSURED:	DOB:	PRI SSN:

SEC INS:	POLICY#:	GROUP#:
NAME OF INSURED:	DOB:	SSN:

~~GUARANTOR INFORMATION~~

NAME:	PHONE #:
ADDRESS:	
CITY:	STATE: ZIP:

CONSENT FOR TREATMENT

The undersigned hereby consents to any medical services rendered to the patient by the physician, employees and contracted healthcare provider of Radiology Imaging Associates.

AUTHORIZATION TO RELEASE INFORMATION

The undersigned authorizes Radiology Imaging Associates to release all or any part of the medical record of the patient named on this encounter form to other healthcare providers, insurance companies, organizations, or agencies as may be concerned with the diagnosis, treatment or payment of the medical services rendered. The undersigned also authorizes other healthcare providers to release all or any part of the medical record of the patient named on this encounter form to Radiology Imaging Associates that may be required to assist Radiology Imaging Associates in patient's diagnosis and/or treatment.

ASSIGNMENT OF INSURANCE BENEFITS

As a convenience to our patients, Radiology Imaging Associates will bill your insurance carrier directly. I hereby assign, transfer and set over to Radiology Imaging Associates all of the rights, title and interest to medical, automobile personal injury protection, or workers compensation medical insurance benefits, and all other rights and privileges otherwise payable to me for those services provided. I also understand that obtaining Pre-certification, authorization or other requirements or conditions of my insurance coverage is my responsibility.

HIPAA PRIVACY POLICY

The undersigned acknowledges that he/she has received a copy of Radiology Imaging Associates Notice of Privacy Policy as required by HIPAA.

FINANCIAL RESPONSIBILITY

The undersigned agrees, whether signing as the patient or an agent, that in consideration of the services to be rendered to the patient, he/she hereby individually obligates himself/herself to be responsible for all or any unpaid portion of the bill incurred. I further understand the unpaid portion of the bill may be insurance deductibles, coinsurance, co-payments or the entire bill, if my insurance carrier denies coverage.

The undersigned certifies that he/she has read the foregoing and understands its terms and is the patient or is a duly authorized representative of the patient and accepts and consents to the above terms.

Signature of Patient/Authorized representative

Date

Witness

Date