

## PATIENT INFORMATION SHEET

Complete the sections that apply to you.

Person to notify in case of emergency:

Phone \_\_\_\_\_

Last Name \_\_\_\_\_

First Name \_\_\_\_\_ M.I. \_\_\_\_\_

Street Address 1 \_\_\_\_\_

Street Address 2 \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Sex (M/F) \_\_\_\_\_ Marital Status  M  S  W

Referring Physician \_\_\_\_\_

Referring Physician's Address \_\_\_\_\_

Employer \_\_\_\_\_

Home Phone # \_\_\_\_\_

Work Phone \_\_\_\_\_

Mobile Phone # \_\_\_\_\_

Date of Birth \_\_\_\_\_

Social Security \_\_\_\_\_

Occupation: \_\_\_\_\_

### INSURANCE INFORMATION

PRIMARY INS. CO. \_\_\_\_\_

PHONE#: \_\_\_\_\_ ID#: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

GROUP NAME/#: \_\_\_\_\_

NAME OF POLICYHOLDER: \_\_\_\_\_

POLICYHOLDER DOB: \_\_\_\_\_

RELATIONSHIP OF PATIENT TO POLICYHOLDER:

SELF  SPOUSE  CHILD  PARENT  OTHER

EMPLOYER INS. PLAN? (CIRCLE ONE) Y OR N

SECONDARY INS. CO. \_\_\_\_\_

PHONE#: \_\_\_\_\_ ID#: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

GROUP NAME/#: \_\_\_\_\_

NAME OF POLICYHOLDER: \_\_\_\_\_

POLICYHOLDER DOB: \_\_\_\_\_

RELATIONSHIP OF PATIENT TO POLICYHOLDER:

SELF  SPOUSE  CHILD  PARENT  OTHER

EMPLOYER INS. PLAN? (CIRCLE ONE) Y OR N

RELATIONSHIP IF OTHER THAN PATIENT \_\_\_\_\_

### CONCERNING INSURANCE

I  AGREE  DISAGREE TO AUTHORIZE WOMEN'S CENTER FOR RADIOLOGY TO FILE INSURANCE ON MY BEHALF FOR COVERED SERVICES RENDERED. I CERTIFY THAT THE INFORMATION I HAVE REPORTED WITH REGARD TO MY INSURANCE COVERAGE IS CORRECT. I FURTHER AUTHORIZE THE RELEASE OF ANY NECESSARY INFORMATION, INCLUDING MEDICAL INFORMATION FOR THIS OR ANY RELATED CLAIM, TO MY INSURANCE CARRIER, (OR, IN THE CASE OF MEDICARE PART B BENEFITS TO THE SOCIAL SECURITY ADMINISTRATION AND HEALTH CARE FINANCING ADMINISTRATION). A COPY OF THE AUTHORIZATION MAY BE USED IN PLACE OF THE ORIGINAL.

THIS AUTHORIZATION MAY BE REVOKED BY EITHER ME OR MY INSURANCE CARRIER AT ANY TIME IN WRITING.

### ASSIGNMENT OF BENEFITS

I  AGREE  DISAGREE TO AUTHORIZE PAYMENT OF ALL MEDICAL INSURANCE BENEFITS WHICH ARE PAYABLE TO ME UNDER THE TERMS OF MY INSURANCE POLICY TO BE PAID DIRECTLY TO WOMEN'S CENTER FOR RADIOLOGY FOR SERVICES RENDERED. I FURTHER AUTHORIZE THE RELEASE OF ANY INFORMATION NEEDED FOR PROCESSING MY INSURANCE CLAIMS. A COPY OF THIS AUTHORIZATION MAY BE USED IN PLACE OF THE ORIGINAL.

I UNDERSTAND AND AGREE THAT I AM FINANCIALLY RESPONSIBLE FOR CHARGES NOT PAID BY MY INSURANCE COMPANY.

### RECORDS RELEASE

I  AGREE  DISAGREE TO ALLOW WOMEN'S CENTER FOR RADIOLOGY TO RELEASE MY FILMS, REPORTS, ETC., TO MY REFERRING PHYSICIAN, SPOUSE, OTHER PHYSICIANS, OTHER RADIOLOGY GROUPS, INSURANCE CARRIERS, ATTORNEYS, ETC. THIS AUTHORIZATION TO RELEASE X-RAYS, REPORTS, ETC., WILL REMAIN IN EFFECT UNTIL IT IS REVOKED BY ME IN WRITING.

I HAVE RECEIVED THE PATIENT BILL OF RIGHTS AND THE NOTICE OF PRIVACY PRACTICES.

Patient's Signature \_\_\_\_\_

Date \_\_\_\_\_

We would like to thank you for keeping your appointment today and appreciate the opportunity to provide you with professional health care.