Women's Center For Radiology

PATIENT INFORMATION FORM

It is important that you provide your complete and current information. Please present your insurance card(s) and photo ID.

Today's Date ☐ New Patient Social Security Number:

Patient's Name: (Per Insurance Card) Date of Birth:

Address: City: St: Zip:

Home Phone: Mobile Phone: Work Phone:

eMail Address:

Preferred Method of Notification: ◯ MAIL ◯ PHONE ◯ eMAIL

Marital Status: ◯ Married ◯ Single ◯ Widowed ◯ Divorced ◯ Other Sex: ◯ M ◯ F

Preferred Language:

Ethnicity: ☐ Caucasian ☐ African American ☐ Hispanic ☐ Asian ☐ Native American ☐ Other

Smoking Status: ◯ Every Day ◯ Some Days ◯ Former ◯ Never ◯ Unknown

Allergies:

Medications:

Employer:

How did you hear about us?

Notify in Emergency: Phone:

Relationship to you:

INSURANCE INFORMATION

1ST POLICY

Carrier: Policy #: Group #:

Address for Claims: City: St: Zip:

Name of Policy Holder: Birth Date:

Relationship to you: Employer:

2ND POLICY

Carrier: Policy #: Group #:

Address for Claims: City: St: Zip:

Name of Policy Holder: Birth Date:

Relationship to you: Employer:

***** PLEASE TURN THIS PAGE OVER AND COMPLETE THE OTHER SIDE *****

WOMEN'S CENTER FOR RADIOLOGY

FINANCIAL POLICY AND PATIENT RESPONSIBILITY STATEMENT

Payment for all services rendered by Women's Center for Radiology are due at the time of service, unless other arrangements have been made.

☐ Check

Medicare Lifetime Signature on File:

I, the undersigned, request that payment of authorized Medicare benefits be made on my behalf to Women's Center for Radiology for any services furnished to me. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents, to determine these benefits payable for related services.

☐ Check

Private Insurance Authorization for Assignment of Benefits/Information Release:

I, the undersigned, authorize payment of medical benefits to Women's Center for Radiology for any services furnished to me. I understand that I am financially responsible for any amount not covered by my contract, such as any deductible, co-payment, co-insurance, non-covered services, or services rendered if my insurance is terminated. I also authorize Women's Center for Radiology to release to my insurance company or their agent information concerning health care, treatment, advice, or supplies, provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

☐ Check

Acknowledgement of Receipt:

I, the undersigned, acknowledge receipt of the documents titled: Patient's Rights and Responsibilities, HIPAA Privacy Practices, and Advanced Directives.

☐ Check

MEDICAL RECORDS RELEASE:

I hereby grant permission to Women's Center for Radiology to release my medical records to my insurance carriers and/or other healthcare agencies and providers for the purposes of continuing care or treatment.

ADDITIONAL AUTHORIZATION TO RELEASE INFORMATION:

The following person(s) are authorized to receive information about my medical condition, treatment, status, or test results. This authorization remains in effect unless cancelled in writing by the patient.

Patient Signature Date