

ADVANCED IMAGING SAN MARCOS

PATIENT INFORMATION

Patient Last Name: _____ First: _____ Middle: _____

Sex: F M Date of Birth: _____ Patient Weight: _____ Social Security#: _____ - _____ - _____

Mailing Address: _____ Apt# _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Employer: _____ Phone: _____

Address: _____ City/State: _____

Emergency Contact Name: _____ Phone: _____ Relationship: _____

Do you currently reside in a Skilled Nursing Facility/Assisted Living Residence? Yes No
If yes, name of facility/residence: _____

Referring Physician: _____ Exam: _____

Symptoms or reason for your test: _____ Date Symptoms Started: _____

FOR INSURANCE PURPOSES:

Is this due to an accident or injury? Yes No Auto: _____ Work Related: _____ Date of accident/injury: _____

If this is a work related injury, please complete the Worker's Compensation Section below:

Employer Name (at time of injury): _____	Date of Injury: _____	Claim#: _____
Employer Contact Name: _____	Phone# _____	
Name of Workers Compensation Company: _____	Claims Adjuster: _____	
Claims Mailing Address: _____	City/State: _____	Zip Code: _____

HEALTH INSURANCE INFORMATION: (Note "subscriber" refers to the individual carrying the insurance:)

PRIMARY INSURANCE: Plan Name: _____ Policy ID#: _____ Group #: _____

Subscriber's Name: _____ SS# _____ DOB: _____

Subscriber's Address: _____ City/State: _____

Patient's relationship to Insured: Self Spouse Child Other

SECONDARY INSURANCE: Plan Name: _____ Policy/ID#: _____ Group #: _____

Subscriber's Name: _____ SS# _____ DOB: _____

Subscriber's Address: _____ City/State: _____

Patient's relationship to Insured: Self Spouse Child Other

GUARANTOR INFORMATION:

Note; For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent (or guardian with custody) for payment. (Person responsible for the bill, Patient is a minor, Legal guardian, etc) Note:

Name: _____ **SS#** _____ **DOB:** _____ **Phone #** _____

Mailing address: _____ **City/State:** _____ **Zip Code:** _____

ASSIGNMENT OF BENEFITS

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments. I hereby assign all medical benefits and hereby authorize and direct my insurance carrier(s), including Medicare, private insurance, and any other health/medical plan, to issue payment check(s) directly to Advanced Imaging San Marcos and San Marcos Medical Imaging (for the Radiologist professional interpretation services), rendered to myself and/or my dependents I further understand that I am responsible for any amount not covered by my insurance company. I further understand that San Marcos Medical Imaging will **bill separately** for the **professional radiologist** interpretation of the services rendered.

AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize Advanced Imaging San Marcos & San Marcos Medical Imaging to: 1) release necessary to insurance carriers regarding my illness and treatments; 2) process insurance claims generated in the course of examination or treatment; and 3) allow a photocopy of my signature to be used to process insurance claims for the period of my lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from Advanced Imaging San Marcos & San Marcos Medical Imaging (the Radiologist professional interpretation services) on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized. I further understand that fees are due and payable on the date that services are rendered and agree to pay, in full, all such charges incurred, immediately upon receipt of the appropriate statement. I understand that I am legally responsible for all charges incurred whether or not they are paid by my health insurance, and that any unpaid balance shall be due in full immediately if insurance proceeds are paid directly to me. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize the release of my medical records, inclusive of all test results and pertinent information acquired during my treatment physicians, nursing facilities and/or other healthcare agencies to which I may be referred and deemed necessary.

I have recieved this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

TREATMENT CONSENT: I am consenting to any procedures performed on this date and these procedures have been explained to me.

Signature: _____
(Patient/Parent/Legal Guardian)

Date: _____

Printed Name: _____