PATIENT INFORMATION

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FIRST NAME MI LAST NAME

____

STREET ADDRESS APT. # CITY STATE ZIP

____

HOME PHONE CELL PHONE WORK PHONE

SSN # _____-_____-_____ DOB: ____/____/____ AGE:_____ SEX: M F MARITAL STATUS: M S D W

PATIENT'S EMPLOYER:____

EMPLOYER'S ADDRESS:____

IN CASE OF EMERGENCY, CONTACT NAME:____

RELATIONSHIP:____________________________CONTACT NUMBER:__________________________

REFERRING PHYSICIAN:____

PRIMARY CARE PHYSICIAN (if different):____

PRIMARY INSURANCE PLAN NAME:____

POLICY HOLDER'S NAME: ____

POLICY HOLDER'S SOCIAL SECURITY #: ________-________-_______ BIRTHDATE: _____/______/_____

POLICY HOLDER'S EMPLOYER:____

SECONDARY INSURANCE PLAN NAME:____

POLICY HOLDER'S NAME: ____

POLICY HOLDER'S SOCIAL SECURITY #: _______-_______-________ BIRTHDATE: _____/_____/_____

POLICY HOLDER'S EMPLOYER:____

EACH INSURANCE COMPANY ALLOWS A CERTAIN AMOUNT TO BE PAID FOR SERVICES PROVIDED. THE WOMAN'S IMAGING GROUP IS AN APPROVED MEDICAL PROVIDER FOR YOUR INSURANCE COMPANY AND WILL FILE YOUR INSURANCE CLAIM(S) FOR YOU. YOUR INSURANCE COMPANY WILL MAKE PAYMENT DIRECTLY TO THE WOMAN'S IMAGING GROUP EXCEPT FOR THE AMOUNT THAT FALLS UNDER YOUR RESPONSIBILITY.

I AUTHORIZE THE WOMAN'S IMAGING GROUP THE RELEASE OF MY RADIOGRAPHIC FILMS/REPORTS AND ANY INFORMATION NECESSARY TO PROCESS MY INSURANCE CLAIM. I HEREBY AUTHORIZE THE WOMAN'S IMAGING GROUP TO RELEASE ANY OR ALL INFORMATION CONTAINED IN MY FILE TO THE ABOVE-DESIGNATED INSURANCE CARRIER OR THIRD PARTY PAYOR FOR THE SOLE PURPOSE OF RECEIVING PAYMENT FOR SERVICES RENDERED. I UNDERSTAND AND AGREE THAT REGARDLESS OF INSURANCE BENEFITS AVAILABLE TO THE PATIENT, I AM FULLY RESPONSIBLE FOR ANY AND ALL FEES THAT ARE DUE THE WOMAN'S IMAGING GROUP FOR THE PROCEDURE(S) AND SERVICES PROVIDED TO THE PATIENT, REGARDLESS OF WHETHER I AM THE INDIVIDUAL RECEIVING THE SERVICES. IF THE INSURANCE COMPANY OR THIRD PARTY PAYOR DOES NOT PAY OR ONLY PARTIALLY PAYS THE WOMAN'S IMAGING GROUP, I AGREE TO BE PERSONALLY RESPONSIBLE FOR FULL PAYMENT. IF IT BECOMES NECESSARY FOR THE WOMAN'S IMAGING GROUP TO UTILIZE THE SERVICES OF A COLLECTION AGENCY AND/OR AN ATTORNEY TO COLLECT ANY PAST DUE AMOUNTS FOR SERVICES RENDERED HEREIN, I FURTHER AGREE TO PAY ALL COSTS OF THE ATTORNEY'S FEES AND COLLECTION AGENCY.

____ DATE:______________________

SIGNATURE OF GUARANTOR

PRIVACY NOTICE ACKNOWLEDGEMENT: THE PRIVACY NOTICE FOR OUR PRACTICE WHICH IS REQUIRED BY LAW IS POSTED IN THE WAITING ROOM. THIS NOTICE INFORMS YOU THAT THE WOMAN'S IMAGING GROUP WILL NOT SELL OR IMPROPERLY HANDLE YOUR PROTECTED HEALTH INFORMATION. WE WILL ONLY USE THIS INFORMATION TO PROVIDE YOU WITH TREATMENT, TO CONDUCT OUR ROUTINE HEALTH CARE OPERATIONS AND TO OBTAIN PAYMENT FROM YOU OR YOUR INSURANCE COMPANY. WE WILL MAKE EVERY ATTEMPT TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION FROM ANY OUTSIDE INTRUSION.

PATIENT SIGNATURE: ____DATE:______________________

WITNESS:____DATE:______________________