MONUMENT 9A IMAGING

Patient Information Form

Name: _____

Last Middle First

SSN: _____ DOB: _____ Ordering Dr. _____

Hm Phone: _____ Wrk Phone: _____ Cell Phone: _____

Home Address: _____ City: _____ Zip: _____

Primary Insurance Name / Policy ID #: _____

Secondary Insurance Name / Policy ID#: _____

Tertiary Insurance Name / Policy ID#: _____

Is your study a result of an auto accident? Yes or No

Is your study a result of a worker's compensation injury? Yes or No

Is this an open claim? Yes or No

Date of injury/accident _____State where accident occurred _____

Insurance Company Name _____ Phone _____

Mailing Address _____

City _____ St _____ Zip _____

Policy Number _____Claim Number _____

Adjuster Name _____ Verified by _____

Assignment of Benefits:

I hereby give authorization of payment of insurance benefits to be made directly to Monument 9A Imaging for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all cost of collection and reasonable attorney's fees. I hereby authorize the healthcare provider to release all information necessary to secure the payment benefits; I further agree that a photocopy of this agreement shall be as valid as the original.

Release of Medical Records:

I hereby give Monument 9A Imaging permission to request and obtain any pertinent medical reports, lab results and x-rays from my physician or hospital/clinic should this be necessary for further evaluation.

I further give my permission to the physician and/or hospital clinic to release medical reports to Monument 9A Imaging.

I also give my permission to release my medical reports to my physician and/or hospital/clinic should this be necessary for further evaluation.

It is my understanding that unauthorized disclosure of this information to a third party is prohibited by state and federal statue. If I want to revoke this release, I must do so in writing and such revocation to be effective from the time of receipt.

Notice of Privacy Practices

I have received and read the "Notice of Privacy Practices" as provided by Monument 9A imaging. This notice describes how health information about me may be used and disclosed, and how I can get access to this information

Authorization for Call Confirmation

Monument 9A Imaging may call to confirm your appointment. In the event that we must leave a message, we may disclose your appointment date, time, and that we are calling from Monument 9A Imaging.

Patient Signature: _____ Date: _____