Advanced Imaging
San Marcos
MRI • CT • ULTRASOUND • X-RAY

PATIENT INFORMATION

Patient Last Name: _____ First: _____ Middle: _____

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

Mailing Address: _____ Apt. # _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Employer: _____ Phone: _____

Address: _____ City/State/Zip: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

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

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/Zip: _____

Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

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HEALTH INSURANCE INFORMATION (continued)

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

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

Subscriber's Address: _____ City/State/Zip: _____

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 parents (or guardian with custody) for payment. (Person responsible for the bill, patient is a minor, legal guardian, etc.)

Name: _____ SS#: _____-_____-_____ DOB: _____

Address: _____ City/State/Zip: _____ Phone: _____

ASSIGNEMNT OF BENEFITS

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangement 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 INFORMAITON

I hereby authorize Advanced Imaging San Marcos and San Marcos Medical Imaging to: 1) release information 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 and 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 an payable on the date that services are rendered for all charges incurred whether or not hereby are paid by my health insurance, and that nay unpaid balance shall be due in full immediately in 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 to physicians, nursing facilities and/or other healthcare agencies t which I may be referred and deemed necessary.

I have received 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: _____ **Date**: _____

(Patient/Parent/Legal Guardian)

Printed Name: _____