Radiology Group, P.C.

Patient Demographic Information

Date: _____

Age: _____ Name: _____ Birth Date: _____

Residence Address: _____ Mailing Address: _____

City: _____State: _____ Zip Code: _____ Home Phone: (____) _____

Cellular: (___) _____ Social Security Number: _____ Sex: **M / F**

Referring physician for today's visit: _____

Emergency Contact Name: _____ Relationship: _____ Phone: (___) _____

Race: Caucasian African American Asian/Pacific Islander American Indian/Alaskan Native

Ethnicity: Hispanic Non-Hispanic **Primary Language**: _____

Employer: _____ Address: _____

City: _____ State: _____ Zip: _____ Work Phone: (____) _____

Responsible Party Billing Information

□ Same as above

Name: _____Birth Date: _____ Home Phone: (____) _____

Address: _____ City/State/Zip: _____ Apt/Suite: _____

Primary Insurance

Insurance Name: _____ I.D. #: _____ Group #: _____

Subscriber Name: _____ Birth Date: _____ Sex: M / F

Subscriber Address: _____ City/State/Zip: _____

Relationship to Patient: _____ Employer Name: _____

Secondary Insurance

Insurance Name: _____ I.D. #: _____ Group #: _____

Subscriber Name: _____ Birth Date: _____ Sex: M / F

Subscriber Address: _____ City/State/Zip: _____

Relationship to Patient: _____ Employer Name: _____

Personal Due Balances

Any accounts not paid in full or on an approved payment plan within 90 days of their first statement are considered delinquent. Delinquent accounts that remain unpaid may also be referred to an outside collection agency. The patient may be held responsible for payment of any court costs and/or attorney fees incurred by the collection agency during their collection process.

Assignment of Benefits

I authorize direct payment of benefits provided under any health care plan or medical expense policy due to me or payable on my behalf to Radiology Group, P.C. I further authorize release of information required by any third party payer regarding this claim. I permit a copy of this authorization to be used in place of the original. I acknowledge that any or all of the expenses not paid by my third-party payer, as defined under my plan benefit contract, are my responsibility.

Applicable to Medicare Patients: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and/or the Medicare program or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf.

_____ _____ _____

Date **Signature of Patient or Person Authorized to consent** Relationship to the Patient