Date: 10/24/13

PATIENT INFORMATION

Patient #:	Gender:	Date of Birth:	Age:
Last Name:		Social Security #:	
First Name: Initial:		Phone:	
Address:		Work Phone:	
City, State, Zip:		Email:	

GUARANTOR INFORMATION

Last Name:	First Name:
Relationship to Patient:	Telephone:

INSURANCE INFORMATION

Primary Insurance:		Policy/Subscriber:
Patient Relationship to Subscriber:	Date of Birth:	Subscriber ID#:
Policy Holder's Employer:		Employer Phone:
Second Insurance:		Policy Subscriber:
Patient Relationship to Subscriber:	Date of Birth:	Subscriber ID#:
Policy Holder's Employer:		Employer Phone:

****** Is this service related to a work injury or auto injury? Yes No Date of injury or accident_____**

Acknowledge of Release of Information And Notice of Privacy Practices

I authorize to file a claim to my insurance carrier and/or the Social Security Administration and its carriers. I authorize the release of medical information necessary to process this claim. I authorize payment directly to and the Radiology group who interprets the exam. I understand I am responsible for charges not covered by my insurance. I authorize release of medical information and/or diagnostic studies to my primary care/referring physician and to other healthcare providers to whom I may be referred for evaluation or treatment.

I acknowledge that I have received a written copy of Notice of Privacy Practices. I also acknowledge that I have been allowed to ask questions concerning this notice and my rights under this notice. I understand that this form will be a part of my permanent record until such time as I choose to revoke this acknowledgement and authorization in writing. If I am not the patient, I represent that I am authorized by law to act for and on the patients' behalf.

We will use reasonable safeguards to avoid unintentional disclosures to protect your privacy during electronic communications and will not use email unless authorized by checking below.

☐ **I authorize the use of unencrypted email for appointment reminders, treatment related questions and/or billing statements.**

Patient's Name (please print) BirthDate Signature Today's Date
(If patient is under 18-need guarantor's signature)

TO BE COMPLETED BY EMPLOYEE IF NO ACKNOWLEDGEMENT CAN BE OBTAINED

Good faith efforts were made to obtain acknowledgement from the patient or patients' authorized agent. The good faith efforts made, and the reason acknowledgement could not be obtained, were:

☐ Patient (or authorized agent) refused to sign after requested to do so
☐ Other (please describe)_____

Employee Name (please print) Signature Date