Patient Info & Authorization

First Name _____ MI_____ Last Name _____

Address_____

City_____ State_____ Zip_____

DOB: _____/_____/_____ Marital Status: S M D W

Home Ph._____ Work Ph._____ Cell Ph._____

Email address: _____

Referring Phys: _____ Other Primary Care Phys: _____

PATIENT'S AUTHORIZATION

I understand that initial screening services ordered by Referring Physician may warrant further diagnostic testing. I authorize and give consent for my provider to bill me directly for recommended services performed that are not covered under the terms of my health plan.

I hereby assign my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for all non-covered services, copays, deductibles and/or coinsurance. I authorize the provider or designated representative to contact me by telephone or mail about appointments, billing and medical care. I authorize the physician to release any medical information required to process this claim.

We participate in the CRISP health information exchange (HIE) to share your medical records with your other health care providers and for other limited reasons. You have rights to limit how your medical information is shared. We encourage you to read our Notice of Privacy Practices and find more information about CRISP medical record sharing policies at www.crisphealth.org. I acknowledge that I have been offered a copy of the Bay Radiology Notice of Privacy Practices.

Pt signature: _____ Date:_____

----------**Lines below are for use at additional (future) visits**----------

I confirm that changes to the above have been made in blue ink today:

Pt signature: _____ Date:_____

Pt signature: _____ Date:_____

Pt signature: _____ Date:_____

Pt signature: _____ Date:_____