Bay Radiology

PATIENT INFORMATION

First Name _____ MI____ Last Name _____

Address_____

City_____ State_____ Zip_____

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

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

E-Mail Address: _____

Referring Phys: _____Primary Care Phys: _____

INSURANCE INFORMATION: PLEASE PROVIDE THE RECEPTIONIST WITH YOUR CARD(S)

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.

*** I acknowledge that I have been offered a copy of the "Notice of Privacy Practices".**

**** <u>There is a FEE to sign out images (cd and films) to cover printing cost</u>****

* _____ _____

Signature of Patient or Subscriber of Beneficiary Date