

Please list the Doctor that referred you here today:

Doctor:

Patient Information

Name _____ Male Female
Date of Birth: _____ SS# _____ (OPTIONAL)
Mailing Address: _____
City _____ State _____ Zip _____
Phone Numbers: Home _____ Cell _____ Work _____
Emergency Contact: Name _____ Number _____
Marital Status: Single Married Divorced Widowed Spouse Name: _____

Primary Insurance (Section needs to be completed, if not fully completed patient will be billed for any services)

Patients relationship to policy holder: Self Spouse Child Other
Insurance Company _____ ID# _____ Group# _____
Policy Holder _____ DOB _____ SS# _____
Policy Holder Employer _____
Employment Status: Full Time Part Time Retired Unemployed Student

Secondary Insurance/Workman's Comp Information

Insurance Company _____ ID# _____ Group# _____
Policy Holder _____ DOB _____ SS# _____
Policy Holder Employer _____

Date of Injury _____ Claim # _____ Claims Address _____

Release of Medical Records

To complete my insurance claim and treatment, I authorize SimonMed Imaging to release my medical records to my physician(s), clinic, hospital or insurance company (including government programs).

HIPAA – Notice of Privacy Practices

I acknowledge that a copy of the Notice of Privacy Practices that outlines how patient confidential information will be used, disclosed, protected, and how I can get access to this information, is available to me upon request.

Financial/Insurance Policy

I hereby assign all insurance benefits to SimonMed Imaging for services performed, as a result of my illness or injury. **Non-insured patients.** I agree that I am responsible for payment at the time of service, unless prior arrangements have been made. **Deductible/Coinsurance.** I assume and agree to pay all applicable deductibles and co-pays. If my deductible is not met, full payment will be collected at time of service. If my deductible is met, my coinsurance amount will be collected at time of service. **Non-covered procedures.** I agree to pay for all non-covered services (preventative or routine) not paid by my insurance. **Collections.** Once an account is placed in collection status all future services must be paid in full at the time of service. I understand that there will also be a \$25.00 returned check fee.

Film Policy

As a referred patient to SimonMed Imaging I understand that I am entitled to one set of films per exam upon request of a referring physician. This set of films belongs to me, the patient, and is part of my medical records. I understand that SimonMed Imaging requires a 24 hour notice to print films.

Referral & Insurance Card Patient Responsibility

I understand that during the check in process, if I do not have my referral and/or insurance card I will be responsible for any payment rendered at the time of service. I also understand that I can avoid this expense by bringing my referral and/or insurance card to my scheduled check in time or I understand that I can call my referring Doctor's office and have these items faxed to SimonMed Imaging before the scheduled exam time.

Signature:

I have read and agree to abide by SimonMed Imaging's policies.

(Print Patient Name)

(Patient/Responsible Party/Signature)

(Date)