ST. THOMAS RADIOLOGY ASSOCIATES, LLC

PATIENT INFORMATION

PATIENT NAME: ____________________

MAILING ADDRESS: ____________________

CITY: ____________________

STATE: ____________ **ZIP**: ____________

HOME PHONE: ____________ **WORK PHONE**: ____________

E-MAIL ADDRESS: ____________________

DATE OF BIRTH: ____________ **SOCIAL SECURITY NUMBER**: ____________

EMPLOYER: ____________________

REFERRING PHYSICIAN: ____________________

EMERGENCY CONTACT:

NAME: ____________ RELATIONSHIP: ____________ PHONE: ____________

There will be a $25.00 service fee for all Returned Checks.

INSURANCE INFORMATION

~~ PLEASE HAVE YOUR INSURANCE CARDS READY FOR PHOTOCOPYING ~~

PRIMARY INSURANCE: ____________________

NAME OF INSURED IF NOT PATIENT: ____________________

DATE OF BIRTH: ____________________

SOCIAL SECURITY NUMBER: ____________________

POLICY#: ____________________

GROUP #: ____________________

SECONDARY INSURANCE: ____________________

NAME OF INSURED IF NOT PATIENT: ____________________

DATE OF BIRTH: ____________________

POLICY#: ____________________

GROUP #: ____________________

****A REFERRAL IS REQUIRED FOR YOUR PROCEDURE AT *ST. THOMAS RADIOLOGY ASSOCIATES, LLC*, IT IS YOUR RESPONSIBILITY TO PROVIDE OUR OFFICE WITH THE REFERRAL. IF YOUR INSURANCE COMPANY DENIES PAYMENT – DUE TO NO REFERRAL – YOU THE PATIENT AGREE TO PAY *ST. THOMAS RADIOLOGY ASSOCIATES, LLC* IN FULL FOR ANY CHARGES INCURRED DURING YOUR VISIT.

PATIENT/GUARDIAN SIGNATURE: ____________________ DATE: ____________

INSURANCE RELEASE INFORMATION

I HEREBY AUTHORIZE THE OFFICE OF *ST. THOMAS RADIOLOGY ASSOCIATES, LLC* TO RELEASE TO MY INSURANCE COMPANY ANY NECESSARY INFORMATION NEEDED TO FILE AND EXPEDITE PAYMENT ON MY CLAIM. I FURTHER ASSIGN ANY BENEFITS PAYABLE ON MY BEHALF TO *ST. THOMAS RADIOLOGY ASSOCIATES, LLC*. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE NOT COVERED BY MY INSURANCE CARRIER. IF WE DO NOT GET ANY TYPE OF RESPONSE BACK FROM YOUR INSURANCE COMPANY WITHIN 120 DAYS, THE BALANCE DUE WILL BE TURNED OVER TO PATIENT RESPONSIBILITY. WHEN AN ACCOUNT IS THE PATIENT'S RESPONSIBILITY AND IT IS NOT PAID AFTER 120 DAYS, YOU WILL BE TURNED OVER TO AN OUTSIDE COLLECTION AGENCY AND A SERVICE FEE WILL BE ADDED TO YOUR ACCOUNT.

PATIENT/GUARDIAN SIGNATURE: ____________________ DATE: ____________