PATIENT INFORMATION SHEET

Patient Acct # (staff use) _____

Valley Imaging Center, Athens, AL

PLEASE GIVE ID CARD & ALL INSURANCE CARDS TO RECEPTIONIST

_____ _____ _____ _____

Title First Name MI Last Name

_____ _____ _____ **Gender:** _____

Social Security Number Date of Birth Current Age Male / Female

Marital Status: _____ Married __ Single ___ Divorced __Widowed **Email:**_____

_____ _____ _____ _____

Address City State ZIP Code

_____ _____ _____

Home Telephone # Work Telephone # Cellular Telephone #

_____ _____ _____

Mother's Name (If Patient is a Minor) Father's Name (If Patient is a Minor) or Legal Guardian Name/ Relationship

_____ _____

Patient's Employer Employer's Address, City, State and ZIP Code

_____ _____ _____ _____

PRIMARY Insurance Contract/ID # Subscriber Name Subscriber DOB

_____ _____ _____ _____

SECONDARY Insurance Contract/ID # Subscriber Name Subscriber DOB

Workman's Comp Injury? __Yes ___ No **Details, if yes**: _____

_____ _____

Emergency Contact Name(s) Relationship

_____ _____ _____

Home Telephone Number Work Telephone Number Cellular Telephone Number

Is patient a resident of a nursing home or an assisted living facility? ___Yes _____No

If yes, which one? _____

RELEASE OF INFORMATION, BENEFIT ASSIGNMENT, PAYMENT AUTHORIZATION, FULL DISCLOSURE AND AGREEMENT TO PAY FOR PROFESSIONAL SERVICES.

I hereby authorize Valley Imaging Center to release any information necessary to process any insurance claim acquired in the course of my examination or treatment to allow a photocopy of my signature to be used to process my insurance claim. I claim, direct, and authorize my carrier to issue payment check(s) directly to Valley Imaging Center for any insurance benefits to which I am entitled. I understand that my failure to disclose any pre-certification, pre-existing, or second opinion requirements for any and all plans to which I subscribe may cause me to incur full liability for professional charges as a result of non-payment by my carrier. Regardless of insurance benefits, if any, I understand that I am fully responsible for any and all fees incurred and I agree the above is a legal and lawful debt. If it becomes necessary to forward this account to collections, I agree to be responsible for any/all collection costs, attorney fees and/or court costs. I realize that in extraordinary circumstances, and when pre-certification requirements are not met, some insurance companies will not pay for certain procedures (i.e. MRI's or Ultrasounds). I understand that my insurance is filed as a courtesy and I am personally responsible for the bill.

_____ _____ _____

SIGNATURE Patient/Responsible Party PRINTED Patient/Responsible Party Name Today's Date