

PATIENT INFORMATION		
Legal Name (Last Name, First Name):		Middle Name:
Preferred Name/Nickname:		SSN:
DOB:	Gender:	Marital Status:
Primary Phone: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work () - - -		Secondary Phone: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work () - - -
Address:		
City:	State:	Zip:
Emergency Contact (Name + Phone Number):		
Email Address:		By checking this box, you are authorizing us to send you statements, payment receipts or other billing information related to todays imaging services: <input type="checkbox"/> Yes <input type="checkbox"/> No
PRIMARY INSURANCE		
Insurance Company:	ID#:	Group#:
Subscriber or Responsible Party Name:	DOB:	Relationship to Patient:
SECONDARY INSURANCE		
Insurance Company:	ID#:	Group#:
Subscriber or Responsible Party Name:	DOB:	Relationship to Patient:

FINANCIAL POLICY: Our office will verify your insurance eligibility; however, we cannot be held responsible for information received when verifying insurance benefits because it is not a guarantee of payment or eligibility. We will obtain an **ESTIMATE** of coverage and out-of-pocket fees from your insurance company prior to the service date. While we request an accurate estimate from your insurer, your final balance may differ from the estimate provided once insurance processes the claim. As a courtesy to you, our billing service (TOM H. PIATT, MD., INC.) will submit your insurance claim(s) for imaging services rendered at this office. We will send a claim to any secondary insurance, so long as this is provided at the time of service. Please be advised that your insurance policy is a contract between you and your insurance company.

I, the undersigned, acknowledge that I understand the above, and agree to be financially responsible for any services I receive regardless of any insurance claim outcome. I further understand that final determination of my claim status is the sole responsibility of my insurance company.

Patient / Guarantor / Responsible Party Signature

Date

By signing below, I hereby authorize PremiereScan and the billing office of TOM H. PIATT, MD., INC. to release all information necessary to secure payment from my insurance carrier(s). (Notice of Privacy Practice available upon request)

Patient / Guarantor / Responsible Party Signature

Date