MRN# _____

PATIENT PERSONAL INFORMATION

Last Name:_____ First Name: _____
Middle: _____

Mailing Address: _____ Driver License (State & #) _____
Apt#: _____City: _____
State: _____ Zip: _____ Marital Status: □ Single □ Married □ Divorced □ Widowed

Home Phone: _____Cell Phone: _____ Work Phone:_____

Date of birth:_____ □ Female □Male Social Security Number: _____

Email address_____

Name of Employer or School:_____

Were you injured at work? (Workers Comp) Yes □ No □ Date of injury:_____

If the injury is related to a personal injury: State where accident occurred:_____

Date of injury:_____ Slip and fall? □ Yes □ No

Motor vehicle accident? □ Yes □ No Other_____

PATIENT'S PRIMARY INSURANCE INFORMATION

Primary insurance company's name_____

Name of Insured: _____ Date of Birth: _____

Relationship to Insured □ Self □ Spouse □ Child □ Other_____

PATIENT'S SECONDARY INSURANCE INFORMATION

Secondary insurance company's name_____

Name of insured: _____ Date of Birth: _____

Relationship to Insured □ Self □ Spouse □ Child □ Other_____

AUTHORIZATION OF RELEASE OF MEDICAL RECORDS AND FILMS

I hereby authorize to release my medical records, diagnostics reports, or CD/films to my referring physician(s). I understand that this authorization shall become effective immediately and shall remain in effect until I revoke it, in writing. I also agree to pay any fee associated with copying of a second set of films/CD. Applicable Fees: $15.00 per sheet of film or per CD or medical records.

Signature: _____ Date: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Street Address: _____City: _____State: _____Zip:_____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

MRN# _____

AUTHORIZATION

ASSIGMENTS OF BENEFITS: I authorize and direct my insurance carrier to pay directly to this provider of medical services any benefits due to me under my insurance plan. I also hereby authorize this provider to use and disclose any of my personal medical information for treatment/ diagnosis and payment (including to my insurance company). I agree to pay the balance of charges not paid under my plan. I understand that a $5 late fee will be added to each additional statement generated for the balance that remains unpaid after 30 days from the initial statement date. I am aware that if my account is not paid in full 90 days from the date of the service, a 30 % additional fee will be added to the balance and it will be sent directly to a collection agency and reported to a national credit bureau. Returned checks will also be charged a $25.00 fee. Should the account be referred to an attorney for collection, the undersigned shall pay attorney's fees and other collection expenses. IF I AM UNINSURED, I am fully responsible for all charges.

Signature: _____ Date: _____

CONSENT FOR MEDICAL TREATMENT/DIAGNOSIS: I authorize the Imaging Center to furnish the necessary medical treatment, or procedures, including diagnostic x-ray, local anesthesia, drugs, and supplies as may be ordered by the attending physician(s), his/her assistants or designees. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatment or diagnostic procedure conducted in the Imaging Center.

Signature: _____Date:_____

LIFETIME MEDICARE B SIGNATURE AUTHORIZATION: I authorize any holder of medical or other information about me to release to the Social Security Administration and center Medicare & Medicaid Services or its intermediaries or carries, or to the billing agent of the Imaging Center any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical benefits be made to the holder of this assignments on my behalf. I understand that I am responsible for any deductible and coinsurance.

Signature: _____Date:_____

In accordance with city, state, and federal laws and regulations, including the health Insurance Portability and accountability act of 1996 (**HIPAA), Carlsbad Imaging/Imperial Radiology** will protect patient records and other information that may reveal a patient's identity when using or disclosing such information for purposes of treatment, payment, health care operations. I am aware that I can request to review the policy of **Carlsbad Imaging/Imperial Radiology** for patient's privacy.

Signature: _____ Date: _____

IF A PATIENT IS UNDER 18: I am the parent or legal guardian of _____

Signature: _____Date: _____

OFFICE USE ONLY

CPT_____ Omnipaque (Q9967) _____cc

CPT_____ Gadavist (A9585) _____cc

CPT_____ Steroid 10mg (J3301) _____cc

CPT_____ Eovist (A9581) _____cc

CREATININE TEST STAMP IF USED 80565

History or complaint: _____

Front desk initial _____ Tech initial _____