Raleigh Radiology Patient Information and Consent Form

Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to your insured, your information on this form may be shared with your insured. Your health information will be kept confidential by your insured.

PATIENT INFORMATION: Today's date: _____

Last Name: _____ Arrival Time: _____

First Name: _____ Examination requested: _____

Middle Initial: _____ Referring MD: _____

Suffix: _____ (example, Jr.; Sr.; III) Date of Birth: _____ / _____ / _____

Sex: Female Male SS #:_____

Mailing Address:_____

(Street or P O Box) City State Zip Code

Home Phone: (_____) _____ - _____ Work Phone (_____) _____ - _____

Mobile Phone (_____) _____ - _____ Email Address _____

If the patient is a minor (under 18 years of age) , please complete the following:

Responsible Party: _____ Relationship: _____

Mailing Address, if different from above: _____

Home Telephone: (_____) _____ - _____ Work Telephone: (_____) _____ - _____

INSURANCE INFORMATION: (A photo ID and ALL insurance cards are required to be presented to Registration for each visit; they will be returned to you.)

Primary Insurance:

Policy Holder: _____ _____ _____ - ____ - _____ ____/____/_____

Last name First Name MI Social Security # Date of Birth

Secondary Insurance:

Policy Holder: _____ _____ _____ - ____ - _____ ____/____/_____

Last name First Name MI Social Security # Date of Birth

Consent & Acknowledgement

I authorize Raleigh Radiology L.L.C. to release any medical or other information needed for this or a related claim. I permit a copy of this authorization to be used in place of the original. If assignment is accepted, I request payment of insurance benefits be made directly to Raleigh Radiology L.L.C. I am responsible for the deductible, co-payment, and non- covered service (as determined by my insurer.) I understand that any deductible or coinsurance payments made on this exam date are estimates based on information Raleigh Radiology received from my insurance company prior to submission of the claim for this exam. Once a claim is submitted to my insurance carrier for the exam, I understand that I may be responsible for additional amounts in accordance with my individual insurance plan and acknowledge that Raleigh Radiology will bill me for the balance remaining. I authorize release of information, films, and copies pertinent to my medical history and for follow-up of any suspicious finding. This consent authorizes Raleigh Radiology to release to my insurance company, referring physician and other physicians participating in my care my medical record, including images and reports. If there are physicians that you would like to designate as NOT ALLOWED to access your medical record, including images and reports, please list them below.

Yourself, or others having your written permission, will be required to present photo I.D. when picking up Medical Records.

Raleigh Radiology has permission to call and leave a message regarding any medical history, results, or my patient information on the voice mail or answering machine for the numbers listed above.

As a patient of Raleigh Radiology, I acknowledge that I had the opportunity to review Raleigh Radiology Notice of Privacy Practices, as required by HIPAA. I understand I may request a paper copy of this policy to keep.

Patient's Signature: _____ ***Date:*** _____

**If patient is a minor, responsible party please sign*

If in the future you believe you may need another individual (family or other) to pick up your medical images and/or reports, please list the person's name, DOB and relationship below.

Name	**Relationship**	**Date of Birth**

Patient's Signature: _____ ***Date:*** _____

**If patient is a minor, responsible party please sign*