

Account #: _____

Date: _____

Referring Physician: _____

Patient Information

Patient Name: _____ Date of Birth: _____ Sex: M ___ F ___

Address : _____
 (street) (city/state) (zip code)

S.S.#: _____ Telephone #: _____ Marital Status: M ___ S ___ D ___ W ___

Accident: Y ___ N ___, Type of accident: W/C ___ MVA ___ Other ___ Date of accident: _____

Illness: Y ___ N ___, Onset of illness _____

Employer: _____ Employment Status: Full-time ___ Part-time ___ Ret- ___

Address: _____ Telephone _____ Child ___ Disability ___

Guarantor Information: (cardholder: child/spouse)

Guarantor Name: _____ Date of Birth: _____ Sex: M ___ F ___

Address: _____
 (street) (city/state) (zip code)

S.S.# _____ Telephone #: _____ Marital Status: M ___ S ___ D ___ W ___

Employer : _____ Employment Status: Full-time ___ Part-time ___ Ret- ___

Address: _____ Telephone _____ Child ___ Disability ___

Primary Insurance Information # (1): (PLEASE GIVE INSURANCE CARD TO RECEPTIONIST)

Insurance Company Name (1): _____ Policy #: _____ Group# _____

Address: _____ Telephone #: _____
 (street) (city/state) (zip code)

Policy Holder Name: _____ Policy Holder DOB: _____ sex: M ___ F ___

Relationship: Patient : ___ Spouse: ___ Mother: ___ Father: ___ Other: ___ (specify) _____

Secondary Insurance Information: # (2) (PLEASE GIVE INSURANCE CARD TO RECEPTIONIST)

Insurance Company Name (2): _____ Policy #: _____ Group # _____

Address: _____ Telephone #: _____
 (street) (city/state) (zip code)

Policy Holder Name: _____ Policy Holder DOB: _____ sex: M ___ F ___

Relationship: Patient: _____ Spouse: ___ Mother: ___ Father: ___ Other: (specify) _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that Diagnostic Radiology Center of the Treasure Coast will not disclose any medical information about me to anyone except my physician, my insurance company or me with exception of the person I have indicated. I hereby give permission allowing _____ to receive medical records and radiology films on my behalf.

Copy of HIPAA Privacy Policy and Consent to Use or Disclose Information for Treatment, Payment or Healthcare Operations, available upon request)

Signature _____ Date: _____

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: _____ Initials: _____ Reason: _____

ASSIGNMENT OF INSURANCE BENEFITS

I understand that I am financially responsible for any medical treatment rendered to me by Ajay K Goyal, MD and/or Diagnostic Radiology Center of the Treasure Coast. This includes any monies not paid by my insurance and which my insurance company deems my responsibility.

I authorize payment of medical benefits due me to be paid directly to Ajay K. Goyal, MD, dba Diagnostic Radiology Center of the Treasure Coast for services rendered by Ajay K Goyal, MD or his staff.

Signature: _____ Date: _____

WE ARE A FILMLESS RADIOLOGY CENTER AND THEREFORE WE NEED 24 HOURS NOTICE TO PRINT YOUR FILMS. THESE FILMS ARE YOURS TO KEEP.

THERE IS NO CHARGE FOR THE FIRST SET OF FILMS YOU RECEIVE, BUT IF A SECOND SET IS REQUESTED, THERE IS A FEE OF \$10.00 PER SHEET.

Initials: _____ Date _____