MIDWEST RADIOLOGY

Please review the information on this form closely. If you need to make any changes to any of the information below, cross it off and provide the updated information on the back side of the form.

PATIENT INFORMATION

Name: _____
Last Name First Name MI

Date of Birth: _____ **Gender:** _____

Home Phone: _____ **Cell Phone:** _____

Email: _____

Mailing Address: _____
Street

_____ _____
City State/Zip

Emergency Contact: _____

INSURANCE & BILLING INFORMATION

- ❑ Check here if your visit is related to an injury at work or motor vehicle accident. You will be asked to provide additional information on the back side of this form.
- ❑ Uninsured / Self Pay Visit
- ❑ Will call with insurance

Insurance Name: _____ **Policy # :** _____

Policy Holder: _____ **Group # :** _____

Guarantor Information (Complete this section only if patient is not responsible for payment)

Name of Guarantor: _____
Last Name First Name MI

Relationship to Patient: _____ **Phone:** _____

Mailing Address: _____
Street

_____ _____
City State/Zip

Assignment of Benefits: I request payment of authorized benefits to be made directly on my behalf to Midwest Radiology Outpatient Imaging - Suburban Imaging for any services provided.

- ❑ Check this box if you are requesting that we do not file any claims from today's visit to insurance. By checking this box, you understand that you cannot reverse this request and will be responsible to pay in full for services provided.

Guarantee and Agreement: I attest that the information above is correct to the best of my knowledge and reflects my current insurance coverage or confirmation that I have no coverage for these services. I agree to be financially responsible for any charges not covered by insurance. I have been advised to provide notification as soon as possible if there are any changes to the information above and that failure to provide accurate coverage information may result in the responsible party having to pay for services that would have been paid by insurance.

_____
Signature of Patient, Legal Representative, or Guarantor **Date**

Printed Name: _____

MIDWEST RADIOLOGY

In the space below, write in any changes to the PATIENT INFORMATION that is on the front side of this form:

Name: _____
Last Name First Name MI

Date of Birth: _____ Gender: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Mailing Address: _____
Street

_____ _____ _____
City State Zip

Emergency Contact: _____

In the space below, write in any changes to the INSURANCE INFORMATION that is on the front side of this form:

Primary Insurance Name: _____
Policy #: _____
Group #: _____
Policy Holder: _____

Secondary Insurance Name: _____
Policy #: _____
Group #: _____
Policy Holder: _____

Name of Guarantor: _____
Last Name First Name MI

Relationship to Patient: _____ Phone: _____

Mailing Address: _____
Street

_____ _____ _____
City State Zip

WORKERS COMPENSATION INFORMATION

Name of Employer: _____

Address: _____
Street City State/Zip

Work Comp. Carrier Name: _____

Address: _____
Street City State/Zip

Contact Name: _____ Contact Phone: _____

Date of Injury: _____ Claim Number: _____

MOTOR VEHICLE INFORMATION

Insurance Company: _____

Address: _____
Street City State/Zip

Name of Policy Holder: _____

Contact Name: _____ Contact Phone: _____

Date of Injury: _____ Claim Number: _____