MIDWEST RADIOLOGY

Patient Information:			
Name:		Home Phone:	
Date of Birth:		Cell Phone:	
Gender:		SSN:	
Address:		Email:	
		Emergency Contact:	
Have you been seen at Midwest Radiology under a different name?			

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

Referring Provider:

Assignment of Benefits

I request payment of authorized benets to be made directly on my behalf to Midwest Radiology for any services furnished to me by Midwest Radiology Outpatient Imaging and/or Midwest Radiology Suburban Imaging, and/or Midwest Radiology Maplewood Imaging.

Guarantee and Agreement to Pay

I agree to be financially responsible for any charges not covered by my worker's compensation insurance, automobile insurance, personal injury carrier, Medicare or my health insurance plan (or, if signed by someone other than the patient, to guarantee payment for the care and treatment rendered to the patient named on this document). If I have no insurance I understand I am financially responsible for all charges incurred.

Patient, Legal Representative or Guarantor Signature — Date Signed

Legal Representative Printed Name (if signing for patient)

I have received a copy of the Notice of Privacy Practices from Midwest Radiology.

Patient or Legal Representative Signature — Date Signed

Legal Representative Printed Name (if signing for patient)