ST. THOMAS RADIOLOGY ASSOCIATES, LLC

PATIENT INFORMATION

PATIENT NAME: _____

MAILING ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ WORK PHONE: _____

E-MAIL ADDRESS: _____

DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER: _____

EMPLOYER: _____

REFERRING PHYSICIAN: _____

EMERGENCY CONTACT:

NAME: _____ RELATIONSHIP: _____ PHONE: _____

There will be a $25.00 service fee for all Returned Checks.

INSURANCE INFORMATION

~~ PLEASE HAVE YOUR INSURANCE CARDS READY FOR PHOTOCOPYING ~~

PRIMARY INSURANCE: _____

NAME OF INSURED IF NOT PATIENT: _____

DATE OF BIRTH: _____

SOCIAL SECURITY NUMBER: _____

POLICY #: _____

GROUP #: _____

SECONDARY INSURANCE: _____

NAME OF INSURED IF NOT PATIENT: _____

DATE OF BIRTH: _____

POLICY #: _____

GROUP #: _____

** A REFERRAL IS REQUIRED FOR YOUR PROCEDURE AT **ST. THOMAS RADIOLOGY ASSOCIATES, LLC,** IT IS YOUR RESPONSIBILITY TO PROVIDE OUR OFFICE WITH THE REFERRAL. IF YOUR INSURANCE COMPANY DENIES PAYMENT - DUE TO NO REFERRAL - YOU, THE PATIENT, AGREE TO PAY **ST. THOMAS RADIOLOGY ASSOCIATES, LLC** IN FULL FOR ANY CHARGES INCURRED DURING YOUR VISIT.

PATIENT/GUARDIAN SIGNATURE: _____ DATE: _____

INSURANCE RELEASE INFORMATION

I HEREBY AUTHORIZE THE OFFICE OF **ST. THOMAS RADIOLOGY ASSOCIATES, LLC** TO RELEASE TO MY INSURNACE COMPANY ANY NECESSARY INFORMATION NEEDED TO FILE AND EXPEDITE PAYMENT ON MY CLAIM. I FURTHER ASSIGN ANY BENEFITS PAYABLE ON MY BEHALF TO **ST. THOMAS RADIOLOGY ASSOCIATES, LLC.** I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE NOT COVERED BY MY INSURANCE CARRIER. IF WE DO NOT GET ANY TYPE OF RESPONSE BACK FROM YOUR INSURANCE COMPANY WITHIN 120 DAYS, THE BALANCE DUE WILL BE TURNED OVER AS PATIENT'S RESPONSIBILITY. WHEN AN ACCOUNT IS THE PATIENT'S RESPONSIBILITY AND IT IS NOT PAID AFTER 120 DAYS, YOU WILL BE TURNED OVER TO AN OUTSIDE COLLECTION AGENCY AND A SERVICE FEE WILL BE ADDED TO YOUR ACCOUNT.

PATIENT/GUARDIAN SIGNATURE: _____ DATE: _____