

Carlsbad Imaging Center  
(760) 730-3536

PATIENT PERSONAL INFORMATION

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle: \_\_\_\_\_

Street Address: \_\_\_\_\_ Apt# \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Driver License (State & #) \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex:  Female  Male Social Security Number: \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Widowed

Name of Employer or School: \_\_\_\_\_

Is your condition a result of work comp?  Yes  No If yes, please give date of injury \_\_\_\_\_

PATIENT'S PRIMARY INSURANCE INFORMATION

Primary insurance company's name \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Relationship to Insured  Self  Spouse  Child  other \_\_\_\_\_

PATIENT'S SECONDARY INSURANCE INFORMATION

Secondary insurance company's name \_\_\_\_\_

Insurance Address: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Relationship to Insured  Self  Spouse  Child  other \_\_\_\_\_

AUTHORIZATION OF RELEASE OF MEDICAL RECORDS AND FILMS

I, \_\_\_\_\_, hereby authorize, the above named facility, to release the medical records, diagnostic report and /or film of:

Patient's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Medical Record# \_\_\_\_\_

Specific exam/exams: \_\_\_\_\_ Date of service: \_\_\_\_\_

To: Name: \_\_\_\_\_ Phone: \_\_\_\_\_

I understand that this authorization shall become effective immediately and shall remain in effect until I revoke it, in writing. I also agree to pay any fee associated with copying of second set of films.  
Applicable Fees: \$15.00 per film

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Turn Over

**EMERGENCY CONTACT**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Street Address: \_\_\_\_\_ Apt# \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**AUTHORIZATION**

† **ASSIGNMENT OF BENEFITS:** I hereby authorize and direct my insurance carrier to pay directly to this provider of medical services any benefits due me under my insurance plan. I also hereby authorize this provider to use and disclose any of my personal medical information for treatment/diagnosis and payment (including to my insurance company). I agree to pay the balance of charges not paid under my plan. I am aware that if my account is not paid in full within 90 days from the date of the service, a 30% additional fee will be added to the balance and it will be sent directly to a collection agency and reported to a national credit bureau. The returned checks will also be charged a \$25.00 fee. Should the account be referred to an attorney for collection, the undersigned shall pay attorney's fees and other collection expenses. **IF I AM UNINSURED, I am fully responsible for all charges.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

† **CONSENT FOR MEDICAL TREATMENT/DIAGNOSIS:** I authorize the imaging Center to furnish the necessary medical treatment , or procedures, including diagnostic x-ray, local anesthesia, drugs, and supplies as may be ordered by the attending physician(s), his assistants or designees. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatment or diagnostic procedures conducted in the Imaging Center.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

† **LIFETIME MEDICARE B SIGNATURE AUTHORIZATION:** I authorize any holder of medical or other information about me to release to the Social Security Administration and center for Medicare & Medicaid Services or it's intermediaries or carriers, or to the billing agent of the Imaging Center any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical benefits be made to the holder of this assignment on my behalf. I understand that I am responsible for any deductible and coinsurance.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**IF PATIENT IS UNDER 18:** I hereby give my permission for \_\_\_\_\_ to be treated at the Imaging Center.

In accordance with city, state, and federal laws and regulations, including the Health Insurance Portability and Accountability Act of 1996 (**HIPAA**), **Carlsbad Imaging Center** will protect patient records and other information that may reveal a patient's identity when using or disclosing such information for purposes of treatment, payment, or health care operations. I am aware that I can request to review the policy of **Carlsbad Imaging Center** for patient's privacy.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_