RADNET MANAGEMENT, INC.

PATIENT INFORMATION FORM

Last Name: First Name: Middle Name:

Previous Name: Gender: ☐ female ☐ male ☐ unknown

DOB: Weight: Height: ft. in.

Address: APT #:

City: State: Zip Code:

(New address if different from above)

By providing my email and cell phone information, I agree to receive email and text messages regarding my important health information.

Home Phone: Cell Phone: Email:

Preferred Language: Smoking Status: ☐ Current Every Day ☐ Never smoked ☐ Former smoker

Race:

☐ American Indian or Alaska Native ☐ Black or African American ☐ White or Caucasian ☐ Decline to Specify

☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ Other Race

Ethnicity:

☐ Hispanic ☐ Not Hispanic ☐ Decline to Specify ☐ Unknown

INSURANCE INFORMATION (if different from patient)

Subscriber Last Name: Subscriber First Name: Subscriber DOB:

Patient's Relationship to Responsible Party: Subscribers Gender:

FINANCIALLY RESPONSIBLE PARTY INFORMATION (if different from patient)

Last Name: First Name:

Patient's Relationship to Responsible Party: Phone:

Address :

City: State: Zip Code:

TO OUR FEMALE PATIENTS

Some imaging procedures are contra-indicated (not recommended) for patients who may be pregnant. If you may be pregnant, please notify one of our team members. By my signature below, I acknowledge that I have read and understand this statement; and state that I am not pregnant, and there is no chance that I may be pregnant.

Signature *Date*

AUTHORIZATION & AGREEMENT

I hereby authorize and direct my Insurance Carrier to directly pay this provider of medical services, any benefits due under my insurance plan. I agree to pay the balance of charges not paid under my plan. I also hereby authorize this provider to use, disclose and or obtain my personal health information for treatment and payment purposes.

If I am UNINSURED, I understand I am fully responsible for all charges.

I understand expenses collected from me at the time of service are only an estimated cost of my visit. If, after my insurance billing process is complete; and additional charges are not paid for under my plan, I am personally responsible for all charges billed regarding any balance due.

I further understand, that ANY emergency or follow-up care needed, is the direct financial responsibility of the patient receiving additional such 3rd party services *(for example: ambulance transport to a hospital, 911 call, physician follow up medical care, etc).*

Signature of Patient or Personal Representative *Date*