PATIENT INFORMATION SHEET

Patient Information:

Last Name: ______________________________ First: ______________________ Middle: __________
Date of Birth: ______-______-________ Sex: M F Social Security #: ________-______-________
Mailing Address: ____________________________________ Home Phone: ( ) ________________
City: ____________________________ State: ___________ Zip Code: ______________

Patient Employer Information:

Name: ____ Phone: ( ) ________________
Address: ________________________________ City: ___________ State: ______ Zip Code: ________

Guarantor Information: (*Primary Policy Insurance Card Holder*)

Name: ____ Relationship to Patient: ____________________
Address: ___________________________ City: __________________ State: ______ Zip Code: ________
(*Only if different from above*)
Employer Name: ____ Work Phone: ( ) ____________
Employer Address: ________________________ City: ___________ State: ______ Zip Code: ________

Visit Information:

When did you receive your Doctor's orders? **Date:** __________________

Insurance Company Information: (*DO NOT fill out if copy of insurance card was made.*)

1. **Primary:**
   Name: ____ Phone #: ( ) ________________
   Address: ________________________ City: __________________ State: ______ Zip Code: ________
   Policy #: ________________________ Group #: ______________________
2. **Secondary:**
   Name: ____ Phone #: ( ) ________________
   Address: ________________________ City: __________________ State: ______ Zip Code: ________
   Policy #: ________________________ Group #: ______________________

Consent to Treatment: The patient is under the control of his referring physician and Alameda Imaging Center (AIC) is not liable for any act or omission in following the instructions of that physician, or in following pre-exam preparations specified by AIC. The undersigned consents to radiologic examination(s) ordered by his referring physician, to be provided by AIC under the general supervision of a radiologist and/or licensed radiology technologist.
Personal Valuables: It is understood and agreed that AIC maintains secured patient lockers for the safekeeping of money and valuables. Patients are to use these lockers for storage of valuables during exams. AIC shall not be liable for the loss of or damage to any patient valuables.
Assignment of Insurance Benefits: In the event that the undersigned is entitled to benefits of any type as part of any insurance policy covering patient or any other party liable to patient, said benefits are hereby assigned to AIC for application to patient's bill. The undersigned shall be responsible for any and all charges not covered by such an insurance policy or policies.
Financial Agreement: The undersigned agrees, whether signing as a patient or an agent, that in consideration of the services to be rendered to the patient, he hereby individually obligates himself to pay any balance outstanding after assignment and payment of insurance benefits. Should the account be referred to an outside agency for collection, the undersigned shall pay reasonable collection and/or attorney expenses. In the event of cash payment for services or if patient is to self-pay, payment in full is due at the time services are rendered.
Release of Information: AIC may disclose all or any part of patient's record to any individual or corporation which is or may be liable under a contract with AIC, to the patient, or to a family member or employer of the patient for all or part of AIC's charges, including but not limited to: hospital or medical service companies; insurance companies; worker's compensation carriers; welfare or public assistance funds; private foundations or charitable organizations; or the patient's or insured's employer(s).

I attest that the information I have provided above is true and accurate, and I agree to the terms outlined above.

____ ____________________
Patient or Insured Signature (Guardian if Patient under 18 years of age) Date

Revised 07/2005