SouthSound RADIOLOGY

Patient Form

Please complete this form and bring it to your appointment

(Please print all information)

Patient Record # (*office use):* _____

Patient Name: (Last/First/M.I): _____

Date of Birth: _____/____/_____ Age: _____ Sex: Male / Female

Responsible Party Name: _____Relationship to patient: _____

Address: _____ Apt.#: ____ City, State, ZIP: _____

Home Phone:_____ Cell: _____ Work: _____

Email address:_____ May we contact you via email/text? Yes /No

Referring physician:_____ Appointment Date: _____

Relation to Subscriber: _____

Financial Agreement and Authorization for Treatment:

I authorize treatment of the person named above and agree to pay all fees and charges for such treatment. I agree to pay all charges for me and members of my family shown by statements, promptly upon presentment thereof, unless credit arrangements are agreed upon in writing. Charges shown by statements are agreed to be correct and reasonable unless protested in writing within thirty days of billing date. In the event legal action should become necessary to collect any unpaid balance due for medical services rendered to me or my family, I/we agree to pay reasonable attorney's fees or other such costs as the Court determines proper. I agree that the venue for any legal action shall be Thurston County.

It is agreed that payments will not be delayed or withheld because of any insurance coverage or pendency of claims thereon, and all proceeds of insurance are assigned to this office where applicable, but without their assuming responsibility for the collection thereof. (A copy of this assignment is as valid as the original.) **I understand that if I am not eligible under the terms of my Medical and Hospital subscriber agreement, or if my exam has not been properly authorized by my PCP and/or insurance company prior to my appointment date, I am liable for all services rendered.**

I understand it is my sole responsibility to check eligibility and coverage issues with my insurance carrier.

THIRD PARTY AUTO INSURANCE CASES ARE THE PATIENT'S RESPONSIBILITY. WE DO NOT WAIT FOR SETTLEMENT.

The above information is for the purpose of obtaining credit & is warranted to be true. I authorize the creditor/agent to make a credit investigation and employment verification.

Signature of Responsible party

Print Name: _____ Signature: _____

Date: _____

Emergency Contact: _____ Phone Number: _____