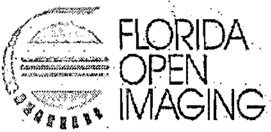

Date: ____________________ Please PRINT the information below:

Patient Name: ____

Mailing Address: ____

City: ____________________ **State:** ______________ **Zip:** ________

Day time Phone: ____________________ **Work Phone:** ____________________

Date of Birth: ____________ **Sex: M / F (circle one)** Social Security #: ______________

Seasonal Residents please enter your alternate mailing address below:

Street: ____

City: ____________________ **State:** ______________ **Zip:** ________

Employer: ______________________

Ordering Physician: ________________

Other Physician(s) to receive a copy of your report(s): ________________

Name of Person to Notify in Case of Emergency: ________________

Phone #:____________ **Relationship to Patient:** ________________

Name of Policyholder: ________________ Patient Relationship to Insured: __________

Policyholder date of birth: ____/____/____ Policyholder Social Security #: _____-_____-_____

Insurance Company Name: ______________________ Phone#: (___) _____-______

Insurance Company Address: ______________________________

Policy #: ______________ Group#: ____________ Claim#: __________

Effective date: ____/____/____ Accident or Injury Date: ____/____/____

Is this an Auto Accident? Y / N (circle one) Is this a Worker's Compensation claim: Y / N (circle one)

Adjustor: __________ Adjustor phone#: (___) _____-______

****

Secondary Insurance Information (provide your insurance card to the front desk at check- in)

Name of Policyholder: ________________ Patient Relationship to Insured: __________

Policyholder date of birth: ____/____/____ Policyholder Social Security #: _____-_____-_____

Insurance Company Name: ______________________ Phone#: (___) _____-______

Insurance Company Address: ______________________________

Policy #: ______________ Group#: ____________ Claim#: __________

1. ACKNOWLEDGEMENT of ASSIGNMENT of BENEFITS

I hereby acknowledge that I have requested medical services from the above referenced facility. In consideration of the services and treatment rendered, I hereby authorize and direct payment of medical benefits to the above referenced facility and assign and all causes of action that I may have against any insurance company (including all coverage for PIP and/or Med-pay, as a result of a vehicular accident), obligated to me by law, statute or contractual agreement, for payment for such medical services and treatment. I direct my insurer to escrow any personal injury protection and/or medical payment benefits to disputes for services and treatments rendered to me by the above referenced facility. I also understand that the medical services rendered by the above could have been obtained by other providers, but chose to obtain said services and treatments from said facility. I also authorize and release any pertinent information or medical records to the above referenced facility, and any other medical provider, insurance company or attorney involved with my medical treatment or cause and/or litigation, that is seeking to obtain payment for medical services and treatment rendered by the above referenced facility or others on its behalf. I hereby direct my insurance company to provide a copy of the PIP log or benefit payout sheet as well as any written explanations as to payments or reductions made or denied or other correspondence pertaining to a claim for services or treatment rendered to me a specified herein. A copy of this assignment shall be considered as valid and effective as the original.

2. AUTHORIZATION for RELEASE of PIP or MED PAY BENEFITS
I hereby authorize my auto insurance carrier to release benefit information, related to the above reference accident, to the above referenced facility.

3. GUARANTEE of PAYMENT
I understand my financial responsibility, and I guarantee a payment for all charges not covered by my insurance, all applied deductibles and co-pays, within 30 days of receiving a statement. MEDICARE PATIENTS: I authorize the release of medical information about me to the Social Security Administration or its intermediaries for my Medicare Claims. I assign the benefits payable for service to the above mentioned facility. If the above referenced facility determines my account must be placed with a collector or an attorney for collection, the cost, including attorney fees, will be paid by the undersigned.

4. NOTICE of PRIVACY PRACTICES
I, the undersigned, authorize the above center to use and disclose my information for purposes of treatment, payment and healthcare operations as described in the Notice of Privacy Practices. I acknowledge that I have been given the Notice of Privacy Practices. I understand that if I have any questions or complaints, I should contact the Privacy Official.

5. VALUABLES STATEMENT
It is often necessary to remove valuables and personal items prior to undergoing an imaging exam. The above referenced facility and employees do not assume responsibility for securing valuables or personal items belonging to patients or visitors. Although lockers may be available, they are intended only as a convenience, and should not be considered secure. I have read the above statement and understand that I am fully responsible for securing my valuables or personal items. I further acknowledge that this facility and its employees are not liable for the loss or theft of these items.

6. CONSENT to TREATMENT
My physician has referred me for an imaging procedure(s). I understand that the practice of medicine is not an exact science, and no guarantee can be made as to the results that might be obtained from this procedure. I understand complications can occur. By consenting to this exam, I hereby consent to the necessary medical and/or surgical actions of the physician and/or colleagues; whomever they choose to consult with to take appropriate actions in regard to this procedure should any complications occur during my visit. I understand by providing consent to the above referenced facility, I may also be providing consent to satellite offices under common ownership.

7. CONSENT TO AUTHORIZE USE OF EMAIL AND TEXT FOR PATIENT BILLING AND FINANCIAL OBLIGATIONS. By my consent below, I authorize the use of any email address or cellular telephone number I provide for receiving **information** relating to my financial obligations, including, but not limited to, payment reminders, delinquent notifications, instructions and links to hospital Patient Billing information.

8. HCA BREAST CARE NETWORK (BCN)
I understand that this center is a member of the HCA Breast Care Network. If the results of my breast study are clinically positive, I understand that my contact information may be provided to the BCN Nurse Navigator, so that she may immediately coordinate with me additional services as needed to determine a final diagnosis.

Acknowledge: _______ (Initial) I consent to use of email for Patient billings and financial obligation purposes.
Acknowledge: _______(Initial) I consent to use of text for Patient billings and financial obligation purposes.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents. An electronic copy and/or photocopy of this consent shall be considered as valid as the original.

______________________________________ ______________

Signature of Patient or Representative **Date**