

Appt Date: _____

CPT _____

CPT _____

CPT _____

READING RAD: _____

Account Notes:

Hippa Date: _____

RESPONSIBLE PARTY (Must be filled in if patient is a minor)

NAME: _____ ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____ HOME PHONE: _____

PRIMARY INSURANCE CARD HOLDER: SELF SPOUSE PARENT OTHER

INSURANCE COMPANY: _____

NAME _____ SS# _____ DOB _____

EMPLOYER NAME _____

SECONDARY INSURANCE CARD HOLDER: SELF SPOUSE PARENT OTHER

INSURANCE COMPANY: _____

NAME _____ SS# _____ DOB _____

EMPLOYER NAME _____

Is this procedure today due to an accident that someone else is responsible for? _____ Yes _____ No

ASSIGNMENT OF BENEFITS & AUTHORIZATION FOR TREATMENT

CONSENT FOR MEDICAL AND SURGICAL TREATMENT: I authorize TOLEDO MEDICAL IMAGING to furnish the necessary medical or surgical treatments, or procedures, including diagnostic, x-ray, and laboratory procedures, anesthesia, drugs and supplies as may be ordered by the attending physician(s), his assistants or his designees. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatment, diagnostic procedures in TOLEDO MEDICAL IMAGING. I recognize that the physicians who practice at TOLEDO MEDICAL IMAGING are employees or agents of TOLEDO MEDICAL IMAGING but are independent contractors. TOLEDO MEDICAL IMAGING may delegate to these independent physicians those services physicians normally provide; and any questions relating to care my physician has given or ordered should be directed to him/her.

ASSIGNMENT OF BENEFITS: I hereby authorize payment directly to TOLEDO MEDICAL IMAGING of any and all medical benefits applicable and otherwise payable to me. I understand that I am financially responsible to TOLEDO MEDICAL IMAGING for charges not covered by this assignment. I also understand that TOLEDO MEDICAL IMAGING is filing my claims as a courtesy to me and that unless stipulated in a contract with my carrier. I am responsible for payment of this claim.

AUTHORIZATION FOR RELEASE OF INFORMATION: I hereby authorize TOLEDO MEDICAL IMAGING to release any information including information regarding diagnosis and treatment requested by the insurance company necessary to collect benefits under the policies started at the time of treatment, or any policies which I subsequently make claim against for hospital services, including related physicians' services on this or related date of service. Unless noted below, this authorization includes but is not limited to, the release of information related to drug, alcohol, HIV antibody and/or psychiatric treatment and/or testing. Withhold from release: _____ I further authorize any physician or institution that attended this patient previously to furnish medical records or information which may be requested by TOLEDO MEDICAL IMAGING or attending physician.

LIFETIME MEDICARE B SIGNATURE AUTHORIZATION: I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers, or to the billing agent of TOLEDO MEDICAL IMAGING any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used on place of the original, and request payment or medical benefits be made to the holder of this assignment on my behalf. I understand that I am responsible for any health deductibles and coinsurance. **NOTE: MEDICARE WILL ONLY PAY FOR A ROUTINE MAMMOGRAM ONCE EACH YEAR.**

MEDIGAP: I request that payment of authorized Medigap benefits be made on my behalf to TOLEDO MEDICAL IMAGING for any services furnished me by them. I authorize any holder of medical information about me to release to _____ any information needed to determine these benefits or benefits payable for related services. I understand that I do not need to provide my supplemental insurer with information concerning this Medicare claim, because my signing this authorization will cause Medicare payment to cross over automatically.

Name if Insured: _____

Medigap Policy: _____
Name of Company Policy Number

LIABILITY/INSURANCE WAIVER: I hereby state that I wish TOLEDO MEDICAL IMAGING to submit my claim for medical services to _____ for services rendered for the accident date of _____.

I am not filing this claim with any other liability insurance and will not be making any claim to another general liability insurance or company I also understand that if I do submit this to any other general liability insurance or company that _____ will have to be refunded immediately and the total amount originally charged for the services rendered will become due and payable by me. Filing your liability insurance does not constitute an assignment. If this is a legal case, we do not accept assignment pending the outcome of your case. You are responsible for your bill in its entirety.

LIABILITY/ATTORNEY-MEDICAL RECORDS RELEASE: I authorize TOLEDO MEDICAL IMAGING to release my medical records to my attorney: **Name** _____ **Phone** _____
Address _____

WORKER'S COMPENSATION: This authorizes my physician to furnish written reports and communicate orally with any representative, attorney for, or investigator from, my Worker's Compensation carrier _____ regarding my examination, diagnosis, treatment and prognosis concerning injuries sustained as a result of an accident occurring on the _____ day of _____, (yr) _____.

IF PATIENT IF UNDER 18: I hereby give my permission for _____ to be treated by DMI.
Patient Name

Print Patient's Name Patient/Guardian Signature Witness Date

THESE AUTHORIZATIONS MUST BE SIGNED IN ORDER TO EXPEDITE THE FILING OF YOUR INSURANCE CLAIM.

Print Patient's Name Patient/Guardian Signature Witness Date

Patient unable to sign due to: _____