

CT/MRI ASSOCIATES _____ TOLEDO MEDICAL IMAGING _____

Patient Name _____ Sex _____ DOB _____

Legal Guardian of Minor Child _____

Address _____ SS# _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Referring Doctor _____ Phone _____

INSURANCE INFO

Name of Insured _____ Sex _____ DOB _____

Relationship to Patient _____ SS# _____

Address of Insured _____

FILM AND REPORT RELEASE

I authorize any prior reports and films to be released to CT/MRI Associates or Toledo Medical Imaging.

Please fax report to 419-885-5414 or to 419-885-1568.

Mail films to 5660 Monroe Street, Suite 7, Sylvania, Ohio 43560.

Signature _____ Date _____

PLEASE READ CAREFULLY BEFORE SIGNING

I authorize CT/MRI Associates or Toledo Medical Imaging to furnish information to my insurance carrier concerning my illness and treatment. I hereby assign all insurance payments to CT/MRI Associates or Toledo Medical Imaging and it's radiological consultants and agree to accept full responsibility for all charges for medical services provided to myself or dependent(s) not paid by my insurance company. I also understand that the calculation of my co-pay/deductible is based on the information supplied to you by my insurance company at the time of predetermination. There is no guarantee of payment amount until my claim has been processed by my insurance company. This bill could possibly be separated into two portions-technical and professional fees.

Signature _____ Date _____