

**Steinberg Diagnostic Medical Imaging
Patient Information Form**

Date: _____ Referring Physician: _____
Social Security Number _____ - _____ - _____ Patient Name _____
Sex: _____ Birth Date ____/____/____ Age: _____ Marital Status _____
Employer: _____
Patient Address: _____
City: _____ State: _____ Zip _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____

Parent / Guardian Information

Is Patient a Minor: _____ (If Yes, Parent / Guardian Information and Signature Are Required)
Parent / Guardian Social Security Number #: _____ - _____ - _____
Parent / Guardian Name: _____ Sex: _____
Birth Date: ____/____/____ Relationship: _____
Address: _____ Phone: _____
Employer: _____ Employer Phone: _____

Insurance Information

We will need your current insurance card and your driver's license or photo ID.

Are You Being Seen Due To An Accident or Injury? _____ Date of Accident: _____
Type of Accident: (Check One) Auto _____ Job Related _____ Other _____

Primary Insurance

Company: _____ Phone: _____
Group: _____ Effective Date: _____ Insurance ID# _____
Policyholder: _____ Relationship to Patient _____
Policyholder Social Security #: ____/____/____ Policyholder Birth Date: _____ Sex _____
Policyholder Employer: _____

Secondary Insurance

Company: _____ Phone: _____
Insurance ID# _____ Group: _____ Effective Date: _____
Policyholder: _____ Relationship to Patient _____
Policyholder Social Security #: ____/____/____ Policyholder Birth Date: _____ Sex _____
Policyholder Employer: _____

Signature

I agree that the above is true to the best of my knowledge.

Patient or Parent / Guardian Signature: _____ **Date** _____

Steinberg Diagnostic Medical Imaging Financial & Health Information Policy

Dear Patient

Thank you for choosing us as your health care provider. The following is our Financial Policy. Our main concern is that you receive the proper and optimal treatments needed to restore your health. Therefore, if you have any questions or concerns about our payment policies, please do not hesitate to contact our billing office.
We ask that all patients read and sign our Financial Policy prior to having an exam.

Cash Patients – payment for services are due at the time services are rendered.

Insured Patients – co-pays, deductibles, and/or 20% of charges are due at the time services are rendered. We accept cash, checks, MasterCard, Discover or VISA for your convenience.

If the insurance company does not pay your balance in full within 30 days, we ask that you contact the carrier to help speed things up. All insured patients are required to sign the assignment of benefits for payment from the insurance company.
Returned checks will be subject to a \$25.00 fee.

Delinquent accounts will be turned over to an attorney or collection agency without notice. Accounts will be considered delinquent if unpaid after 60 days. In the event your account is turned over for collection, you will be responsible for a collection fee equal to 30% of the outstanding balance. Interest, court costs, and other fees may also apply.

Assignment of Benefits

I hereby guarantee payment of all charges incurred at the office of Steinberg Diagnostic Medical Imaging. I hereby assign and direct to pay any and all benefits for medical services provided by SDMI directly to Steinberg Diagnostic Medical Imaging. I hereby authorize the release of medical information required to process my claim.

I have read and agree to the terms spelled out in the financial policy and benefits assignment. I understand that this assignment applies to all services performed at Steinberg Diagnostic Medical Imaging and is in effect until specifically revoked in writing. I further agree that I will ultimately be responsible for payment for all charges incurred should my insurance company fail to pay.

Patient's Signature: _____ Date: _____

Health Information Policy

I have received a copy of Steinberg Diagnostic Medical Imaging's (SDMI) Notice of Privacy Practices detailing how my information may be used and disclosed as permitted under federal and state law.

I understand that SDMI may leave a message on my answering machine or with a third party regarding limited health information, pending appointments, and the time and place of scheduled appointments, or other healthcare related communications.

I understand that SDMI may disclose health information with other entities, such as my insurance company for purposes of treatment, payment, or business operations.

I authorize the following person(s) access to the use or disclosure of my health information. I understand that this authorization is in effect until specifically revoked in writing:

Patient / Parent / Guardian Signature _____ **Date** _____

Again, thank you for choosing us as your health care provider. We appreciate your trust in us and we appreciate the opportunity to serve you.