

**Steinberg Diagnostic Medical Imaging
Patient Information Form**

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

Parent / Guardian Information

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

Insurance Information

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

Primary Insurance

Insurance Name: _____
Insurance ID# _____ Group#: _____ Effective Date: _____
Insured's Name: _____ Relationship to Patient _____
Insured's Social Security #: ____ - ____ - ____ Insured's Birth Date: ____ / ____ / ____ Sex _____
Insured's Employer: _____

Secondary Insurance

Insurance Name: _____
Insurance ID# _____ Group#: _____ Effective Date: _____
Insured's Name: _____ Relationship to Patient _____
Insured's Social Security #: ____ - ____ - ____ Insured's Birth Date: ____ / ____ / ____ Sex _____
Insured's 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 co-insurances 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 any costs, including collection fees, interest, court costs, and other fees associated with collecting the debt.

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.