`SPECTRUM RADIOLOGY ASSOCIATES, PLLC

PATIENT INFORMATION FORM

Referring Physician:_____ **Date:**_____

Name: _____ ____ _____
First MI Last

Address:_____ _____ _____ _____
City **State** **Zip Code**

Date of Birth ___/___/___ **E-Mail Address** _____

_____ _____ _____
Home Telephone **Work Telephone** **Cell Phone**

IS THIS WORKERS COMPENSATION? **( ) YES** **( ) NO**

IS THIS NO FAULT? **( ) YES** **( ) NO**

1. _____ _____ _____
Primary Insurance **Identification Number** **Group Number**

Subscriber Name _____ Birth Date:_____

Relationship to patient: [ ] Self [ ] Spouse [ ] Child [ ] Other

Emergency Notification: Name_____**Telephone #** _____

RACE: [ ] White [ ] Black/African American [ ] Asian [ ] American Indian
[ ] Alaska Native [ ] Native Hawaiian/Other Pacific Island [ ] Other

ETHNICITY: Spanish/Hispanic Origin [ ] Not of Spanish/Hispanic Origin [ ]

LANGUAGE: English [ ] Other [ ]

PLEASE READ AND SIGN OTHER SIDE

For Office Use Only

Patient Account Number _____

Spectrum Radiology Associates, PLLC 1150 Youngs Road Williamsville, New York 14221

Billing, Insurance and your financial responsibility: We will bill your insurance directly if you have the information with you today. You will be responsible for any coinsurance, deductible, copays or other amounts determined by your insurance company.

Copays: Copays are due at the time of service. Failure to pay your copay will result in a $10.00 service fee. If you receive service through more than one radiologist or modality, your insurance company determines the number of copays that you are responsible for.

Authorization: If you do not provide any required authorization from your ordering physician, prior to this service, you agree to be responsible for payment of all charges.

Advance Quotations: Fees quoted in advance do not guarantee that additional imaging provided will be included in the quote.

Release of Outside Records: Occasionally we may require additional imaging or outside comparison films/records for accurate diagnosis. Your signature below allows us to request such records.

Radiologist Discretion: Occasionally, in their professional capacity, the Radiologist may require additional imaging or modify procedures to obtain the most definitive diagnosis. Your signature below allows us to bill your insurance and/or you for associated fees.

Collection and Attorney Fees: If your account is placed in collection, you will be responsible for all collection/attorney fees.
Participating Insurance: We will bill all participating insurances directly and bill you according to their adjudication of the claim. You will be responsible for all amounts deemed by your insurance to be "patient responsibility".

Incomplete Insurance or No Insurance: If you have incomplete insurance or no insurance, payment is required at the time of service. We accept cash, check or credit card.

Minor Child: I am aware my minor child will be receiving Radiology services from Spectrum Radiology today and I give my consent. The service that will be provided has been explained to me.

Parent/Guardian Signature: _____ Date _____

Personal Valuables: It is understood and agreed that money, jewelry and other valuables are my responsibility and that SRA shall not be liable for the loss or damage to my property.

Medical Consent: I consent that the medical staff of Spectrum Radiology may perform all procedures as may be directed by my physician. I am aware that no one at Spectrum Radiology has given assurance as to the success or result of such treatment.
I hereby authorize to pay and/or assign all benefit payments to Spectrum Radiology for services rendered to me. I have read and understood the notice of privacy practices and authorize said assignee to release such information requested by my physician and insurance to secure payment. I hereby agree that all insurance and demographic information provided today is true and accurate

SIGNED: _____ **DATE:** _____

WITNESS: _____ **DATE:** _____