CAPITAL IMAGING, LLC

PATIENT INFORMATION:

Patient Last Name: _____ First: _____ MI: _____
Address: _____ Apt: _____
City: _____ State: _____ Zip: _____
Phone: Home _____ Work _____
Sex: M / F Date of Birth (M/D/Yr): _____ Age: _____
Marital status: (S)(M)(D)(W) Social Security #: _____
Employer Name: _____
Emergency Contact: _____ Phone: _____

IF PATIENT IS A MINOR:

Parent/Guardian Name: _____ Relationship: _____
Address, if different: _____Phone: _____
City: _____ State: _____Zip: _____

WORK COMP INJURY? _____ AUTO ACCIDENT INJURY? _____

PATIENTS MEDICAL INSURANCE (Please provide card)

Name of Insurance Company: _____
Subscriber Name: _____ Relationship to Pt.: _____
Subscriber's Social Security #: _____ Subscriber DOB: _____
Employers Name (Group): _____
ID #: _____ Group #: _____
Secondary Insurance Company: _____
Subscriber's Name: _____ Relationship to Pt: _____
SS#: _____ DOB: _____ ID# _____ Group # _____

I hereby authorize ***Capital Imaging, LLC*** to apply for benefits on my behalf for covered services rendered. I request payments from Blue Shield/Carefirst, Medicare and/or _____(name of insurance company) be made directly to the above provider.

I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim, to the above named billing agent (or in case of Medicare part B benefits, to the Social Security Administration and Health Care Financing Administration) and/or the insurance company named above. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or the above named carrier at any time in writing.

I request the payment of authorized Medigap benefits be made either to me or on my behalf to the above named provider for any services furnished me by this physician/supplier. I authorize any holder of medical information about me to release to Capital Imaging, LLC any information needed to determine those benefits payable for related services.

I understand that in the event that my insurance denies the claim or I fail to obtain all of the necessary information, I will be fully responsible for all payments. If it is necessary to turn this account over to a collection agency/attorney, I agree to pay all reasonable costs of collections, attorney fees and a one time service charge of 25% of the balance due.

_____ _____ _____
Patient Signature Date Office Staff Witness