

## Patient Information, Assignment of Benefits and Release of Information

Patient Name \_\_\_\_\_ MRN \_\_\_\_\_

Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_ Male  Female

Ethnicity: **(Circle One)** Caucasian/White African American/Black Hispanic/Latino Asian Middle Eastern Pacific Islander  
Native American/Alaskan Other

Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_ Relation \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Phone # \_\_\_\_\_

May we send you an e-mail to follow-up on the quality of service we provide today? Y / N Email \_\_\_\_\_

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### My signature and date below authorizes and acknowledges:

- Authorizes Progressive Radiology to direct bill Medicare, Medicaid, Medicaid Supplemental or any other insurance on my behalf.
- Authorizes the release of my medical information to my physician and to Medicare, Medicaid, Medicare Supplemental or other insurance and their agents and assigns.
- Authorizes and gives my permission to Progressive Radiology to obtain pertinent records from a hospital, medical facility or care provider who has been involved in my healthcare. Progressive Radiology may request medical records, for example prior imaging reports (CT, MRI, US, X-Ray) or surgical/pathology reports, which pertain to the reasons I am seeking care on this visit. This information will not be distributed beyond Progressive Radiology, and will be kept confidential.
- Authorizes Progressive Radiology to obtain medical or other information necessary in order to process my claim(s) including determining eligibility and seeking reimbursement.
- Acknowledges that I am financially responsible for any service not covered by my insurance as well as any co-payments, co-insurances and deductibles. I understand that if my account becomes delinquent, a rate of 1.5% will be applied monthly to the delinquent balance until the debt is paid in full.
- Acknowledges that should collection proceedings or other legal action become necessary, I understand that Progressive Radiology has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect my unpaid account. Further, I understand that in addition to my account balance, I am responsible for all attorney's fees, court costs, collection agency costs, and other assessments incurred to collect my unpaid account balance.
- Acknowledges that I have access to a copy of Progressive Radiology's **Notice of Privacy Practices** which is available in the reception area of the facility.
- I hereby attest that I have provided all insurance coverage applicable for services performed at this time. In the event that there is insurance coverage requiring pre-certification and it is not disclosed at the time of service, I will be held responsible for any outstanding balance due to lack of pre-certification.
- **FOR MINORS ONLY:** For Parents/Guardians of Minors: I, \_\_\_\_\_, the parent/legal guardian of \_\_\_\_\_ hereby give my consent for this test.

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Signature of Patient/Parent/Guardian

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Date