COASTAL IMAGING

Patient Information Form

Date:_____

☐ Male ☐ Female

Name:_____ Date of Birth:_____ SSN:_____

Mailing Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Work Phone:_____ Cell phone:_____

Name of Parent/Guardian (for minors only):_____ Phone:_____

Address (if different from patient):_____

Emergency Contact Name:_____ Contact Number:_____

Patient Guarantor Employer Information

Employer's Name:_____ Address:_____
Occupation:_____ Phone:_____

Responsible Party

Primary Insurance:_____ SecondaryInsurance:_____

Assignment and Release:

The signature below serves as authorization for the release of medical information from patient's other healthcare providers for purpose of treatment and for services rendered by Coastal Imaging for the above named patient. This signature will also serve as a release of information necessary to file insurance and assign benefits otherwise payable to policy holder, to the physician or group indicated on the claim. I authorize direct payment from my insurance company to Coastal Imaging. I understand I am financially responsible for any balance not covered by the insurance carrier.

We will file non-contracted insurance as a courtesy: however, if we have no response from your insurance company within 60 days, the charges will be transferred to your responsible party.

Signature:X_____ Date:_____

For office use only:_____ Date:_____

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Patient Financial Policy

Thank you for choosing our imaging center. We are committed to providing the best possible medical care. The following information is provided to avoid any confusion regarding payment for professional medical services.

Payment Policy

- You will receive one bill for services provided at Coastal Imaging that includes the exam performed and professional interpretation.
- Payment is due at the time services are rendered unless other arrangements have been made by either you or your insurance company.
- We accept cash, check, Visa and MasterCard.
- Patients are responsible for their deductible or charges not reimbursed by insurance.
- If the patient is a minor (18 years or younger), the parent or guardian is responsible for payment of the account, accordance with policy outlined above.
- As a courtesy, we will automatically file your insurance claims; therefore we will request a copy of your insurance card at the time of each visit.
- For services estimated to cost more that $200.00, we will accept a minimum payment of half of the expected bill. Upon request, a short-term payment arrangement can be considered.
- You will receive monthly statements. If your account is not paid within 60 days your account will be considered past due.
- Patients having health insurance will be expected to contact their insurance carrier if there is a delay in payment. Please understand that insurance is a contract between you and your carrier, therefore, you are ultimately responsible for your bill.
- If you have difficulty paying your account, please contact our billing department.
- In cases of divorce, the parent who brings the child/children in for treatment is responsible for payment: there are no exceptions.

Referrals

It is your responsibility to bring any required referrals for treatment at, or prior to, the time of your visit. If you do not have a referral, your visit will be rescheduled, or you may be financially responsible.

Acknowledgment and Authorization

I have read, understand and agree to the above policies. I understand the charges not covered by my insurance company, as well as co-payments and deductibles are my responsibility.

I authorize my insurance benefits be paid directly to Coastal Imaging.

I authorize Coastal Imaging to release any medical or other information to my insurance company when requested.

Patient Name X _____ Date _____

Patient's Signature X _____ Parent/Guardian _____
(If patient is a minor)

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Patient Record of Disclosures

In general, HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of protected health information (PHI). The individual is also provided the right to request confidential communications of PHI by alternative means, such as sending correspondence to the individual's office instead of their home.

I wish to be contacted in the following manner: (Check all that apply)

__ Work telephone __Ok to leave message with detailed information

__ Home telephone __Ok to leave message with detailed information

__ Written communication __ Ok to mail to my home address

***Please list only persons able to discuss treatment, appointments, release prescriptions and/or medical records on your behalf in your absence. Note: All persons listed must present valid ID when acting as your representative.

Please print authorized persons only:

1._____ __Appts ___RX __All records

2._____ __Appts __RX __All records

3._____ __Appts __RX __All records

Patient's signature X_____ Date X_____

Acknowledgement and Receipt of HIPAA Policies and Procedures

I _____ hereby acknowledge that I have received and reviewed the HIPAA policies and procedures, detailing how information may be used and disclosed as permitted under federal and state law.

I understand that I am responsible for complying with the policies and procedures and that I am required to see guidance from the Privacy Officer if I have any question or concerns regarding patient confidentiality.

Patient/Guardian signature X_____ Date X_____

Witness:_____ Date:_____