



PARTNERS WITH ST. DOMINIC HEALTH SERVICES

# Patient Information Sheet

## PATIENT INFORMATION

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ MI: \_\_\_\_\_

Date Of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Patient's Relationship To Insured: \_\_\_\_\_ Patient's Referring Physician: \_\_\_\_\_

Is Patient's Condition Related To: Employment? Yes \_\_\_\_\_ No \_\_\_\_\_

Auto Accident? Yes \_\_\_\_\_ No \_\_\_\_\_

Other Accident? Yes \_\_\_\_\_ No \_\_\_\_\_

## INSURANCE INFORMATION

### PRIMARY INSURANCE

Policy Holder's Full Name: \_\_\_\_\_

Date Of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Insurance Company's Name/Address: \_\_\_\_\_

Insurance Company's Phone #: \_\_\_\_\_ Insured's Employer: \_\_\_\_\_

Group #: \_\_\_\_\_ Policy #: \_\_\_\_\_

*(If You Have Medicare, You Won't Have A Group #)*

*(Policy # May Be Certificate, Medicare, Or Social Sec. #)*

### SECONDARY INSURANCE

Is The Patient Covered By Another Health Benefit Plan or Supplemental Insurance? Yes \_\_\_\_\_ No \_\_\_\_\_

Other Health Plan Policy Holder Full Name: \_\_\_\_\_

Date Of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Insurance Company's Name/Address: \_\_\_\_\_

Insurance Company's Phone #: \_\_\_\_\_ Insured's Employer: \_\_\_\_\_

Group #: \_\_\_\_\_ Policy #: \_\_\_\_\_

*(If You Have Medicare, You Won't Have A Group #)*

*(Policy # May Be Certificate, Medicare, Or Social Sec. #)*

## EMERGENCY CONTACT INFORMATION

Emergency Contact's Full Name: \_\_\_\_\_

Relationship To Patient: \_\_\_\_\_

Primary Phone #: \_\_\_\_\_

Secondary Phone #: \_\_\_\_\_

## Section I: Financial Agreement & Assignment of Benefits

In consideration for the services to be rendered to me, I hereby assume full responsibility to pay for those services in accordance with the rates now in effect at Madison Medical Imaging (MMI), to the extent that I am legally responsible for such payment. Payments that I am responsible for may include, but are not limited to, balance after insurance, non-covered services, and deductibles.

I hereby assign to MMI any and all benefits for services rendered under insurance policies, reimbursement, or pre-paid healthcare plans. I acknowledge any balance not covered or paid for by such policies is my legal responsibility

**THIS IS A LEGAL FINANCIAL AGREEMENT OF BENEFITS FORM. BE SURE ANY QUESTIONS YOU MAY HAVE ARE ANSWERED BEFORE YOU SIGN AT THE BOTTOM OF THE PAGE.**

## Section II: Receipt Acknowledgement for the Notice of Privacy Practices

I, \_\_\_\_\_ have been made aware of the Notice of Privacy Practices for MMI  
I understand that this notice states how MMI may use and disclose my Protected Health Information ("PHI").  
I UNDERSTAND THAT A COPY OF THIS NOTICE IS AVAILABLE UPON REQUEST.

## Section III: Consent for Treatment

I authorize MMI to perform all exams, tests, procedures, injections, and any other care deemed necessary or advisable for the diagnosis and treatment of my medical condition(s).

## Section IV: Consent for Release & Acquisition of Medical Records

In order to provide the most accurate reading of my current studies and to assure that I am receiving the highest quality of care, I consent to MMI obtaining any of my previous images, radiology reports, pathology reports, or results of surgical intervention for comparison to my current studies and to track abnormal results. For the same purpose, MMI may release my studies done at an MMI facility to my treating physicians, upon their request.

In order for MMI to obtain and release my records in a timely manner, I authorize MMI to transport my records and images by certified mail or by courier, when necessary.

I understand that any films released from MMI are the property of MMI and the return of such films to the proper MMI facility is the responsibility of the facility or individual to whom they were released.

## Section V: Release of Records to a Designated Third-Party

In addition to my treating physicians and medical facilities, I authorize MMI to release my records and images to the following individuals. (This should include **friends or family members** responsible for picking up your records when you are unable to do so.) **PLEASE PRINT**

1.) \_\_\_\_\_

2.) \_\_\_\_\_

## Section VI: Contacting You At Work

May we call your place of work?

Yes \_\_\_\_\_

No \_\_\_\_\_

May we leave you a message on your voice mail at work?

Yes \_\_\_\_\_

No \_\_\_\_\_

## Patient Signature

By signing below I am verifying that I have read each of the six sections on this page. I understand each section and consent to and agree with the information stated in each section.

\_\_\_\_\_  
(Patient/Legal Representative Signature)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Legal Representative's Relationship To Patient)

\_\_\_\_\_  
(Patient's Printed Name)

\_\_\_\_\_  
(Witness Signature)

\_\_\_\_\_  
(Date)