Advance Technological Radiology, P.A.

E-MAIL:				**Pt. Balance Due:**	
PATIENT NAME:				DOB:	SEX:
ADDRESS:				HOME #:	
CITY:	ST:	ZIP:		CELL #:	
EMPLOYER:				WORK #:	

INSURANCE INFORMATION

PRI INS:	POLICY#:	GROUP#:
SUBSCRIBER:	DOB:	SSN:

SEC INS:	POLICY#:	GROUP#:
SUBSCRIBER:	DOB:	SSN:

GUARANTOR INFORMATION

NAME:		PHONE #:
ADDRESS:		
CITY:	ST:	ZIP:

Medical facilities are now required to collect health related information as part of healthcare reform. This is designed to improve the health of our patients and the quality, safety, and efficiency of healthcare systems.

CURRENT MEDICATIONS: ☐ **NONE** **Please List:** _____

MEDICATION ALLERGIES: ☐ **NONE** **Please List:** _____

Smoking History: ☐ Non-Smoker ☐ Former Smoker ☐ Current Smoker

Are you of Hispanic or Latino ethnicity? ☐ Yes ☐ No

Race (Select one or more): ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ White ☐ Other

What language do you usually speak? ☐ English ☐ Spanish ☐ Other _____

☐ **Decline to answer** ☐ **No Change** **LDOS:** ___/___/___

CONSENT FOR TREATMENT

The undersigned hereby consents to any medical services rendered to the patient by the physician, employees and contracted healthcare provider of A.T. Radiology, P. A.

AUTHORIZATION TO RELEASE INFORMATION

The undersigned authorizes A.T. Radiology, P.A. to release all or any part of the medical record of the patient named on this encounter form to other healthcare providers, insurance companies, organizations, or agencies as may be concerned with the diagnosis, treatment or payment of the medical services rendered. The undersigned also authorizes other healthcare providers to release all or any part of the medical record of the patient named on this encounter form to A.T Radiology, P.A. that may be required to assist A.T. Radiology, P.A, in patient's diagnosis and/or treatment.

ASSIGNMENT OF INSURANCE BENEFITS

As a convenience to our patients, A.T. Radiology, P.A will bill your insurance carrier directly. I hereby assign, transfer and set over to A.T. Radiology, P.A all of the rights, title and interest to medical, automobile personal injury protection, or workers compensation medical insurance benefits, and all other rights and privileges otherwise payable to me for those services provided. I also understand that obtaining Pre-certification, authorization or other requirements or conditions of my insurance coverage is my responsibility.

HIPAA PRIVACY POLICY

The undersigned acknowledges that he/she has received a copy of A.T. Radiology, P.A Notice of Privacy Policy as required by HIPAA.

FINANCIAL RESPONSIBILITY

The undersigned agrees, whether signing as the patient or an agent, that in consideration of the services to be rendered to the patient, he/she hereby individually obligates himself/herself to be responsible for all or any unpaid portion of the bill incurred. I further understand the unpaid portion of the bill may be insurance deductibles, coinsurance, co-payments or the entire bill, if my insurance carrier denies coverage.

The undersigned certifies that he/she has read the foregoing and understands its terms and is the patient or is a duly authorized representative of the patient and accepts and consents to the above terms.

_____ _____

Signature of Patient/Authorized representative Date

_____ _____

Witness Date