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Assured Imaging Office Headquarters:
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PATIENT INFORMATION AND ACKNOWLEDGEMENT FORM

MRN: \_\_\_\_\_

Form with fields for Patient Information (Last Name, First Name, MI, DOB, Age, Sex), Mailing Address, Doctor, SELF-PAY, Medicare, Insurance Information (Primary and Secondary), etc.

ACKNOWLEDGEMENT OF BILLING, PATIENT RIGHTS AND PRIVACY PRACTICES:

I, \_\_\_\_\_ acknowledge that I have received and reviewed a written copy of my Patient Rights and Privacy Practices from Assured Imaging prior to the rendering of any service. I understand that my primary insurance will be billed. If payment is disallowed in whole or in part, I understand that I am responsible for payment of the balance due.

CONSENT TO PROCEDURE(S): Note: If you are pregnant, or think you are pregnant, inform the technologist at once.

I, \_\_\_\_\_ hereby consent to the performance of a (please check all that apply):

- 2D Mammogram Screening, 3D Mammogram Screening, Breast Ultrasound, DEXA, General Ultrasound, General X-Ray, Retinopathy Screening, A1C, Urinalysis, Skin Cancer Screening, Heart Health Screening\*, Pelvic Exam/Tests

X \_\_\_\_\_ Date: \_\_\_\_\_
Patient/Parent/Legal Guardian Signature

X \_\_\_\_\_ Date: \_\_\_\_\_
Witness Signature