assuredimaging

Assured Imaging Office Headquarters:
7717 N. Hartman Lane, Tucson, AZ 85743
Phone: 888.233.6121 Fax: 520.572.7138

PATIENT INFORMATION AND ACKNOWLEDGEMENT FORM

MRN:_____

Last Name	First Name	MI	DOB	Age	Sex
					☐ F ☐ M

Mailing Address	City	State	Zip Code	Home Phone	Alternate Phone

Doctor	Doctor Address	Doctor Phone

SELF-PAY ☐ **receipt number:** | **Do You Have Medicare?** ☐ NO ☐ YES, # | **Auto Accident or Workers Comp related?** ☐ NO ☐ YES

PRIMARY Insurance Information: *(please present card for photocopying)*

Insurance Company	Policy #	Group #

Policy Holder's Name	Policy Holder's DOB	Policy Holder's Employer

Policy Holder's Relationship to Patient	Policy Holder's SSN#	Patient's SSN#

SECONDARY Insurance Information: *(please present card for photocopying)*

Insurance Company	Policy #	Group #

Policy Holder's Name	Policy Holder's DOB	Policy Holder's Employer

Policy Holder's Relationship to Patient	Policy Holder's SSN#	Patient's SSN#

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.*** I understand that if the insurance company denies the claim because I do not disclose the Social Security Number of the insured, I will be responsible for payment.

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*** ☐ **Other**_____

***HEART HEALTH SCREENINGS ONLY:** I understand that Assured Imaging's Sonographer performs the ultrasound scan and notes any findings outside of normal limits. Measurements (if applicable) will be taken and noted in a report. I understand I will receive a hard copy at the time of screening and a report will be mailed to my PCP. Assured Imaging encourages me to follow up with my health care provider. I have been informed Assured Imaging's sonographers do not have the authority to diagnose and that is why I am given the option to have my scan read by Assured Imaging's licensed radiologist. The final report will go right to my health care provider for follow up and/or treatment. The fee to have my ultrasound scan sent and read by an Assured Imaging licensed radiologist is $40.00.

X_____ Date: _____ **X** _____ Date: _____

Patient/Parent/Legal Guardian Signature **Witness Signature**