ADVANCED IMAGING CENTER OF AMARILLO

7010 W. 9th Ave.
Amarillo Texas 79106
806-351-8484 Fax 806-351-8489
Amarilloimaging.com

Patient's Information

MR#: [MRN]

Name: _____ (Last) _____ (First) ____ (MI) ____ (Sex) _____ (DOB) _____ (Social Security #)

Address: _____ (Street) _____ (Apartment #) _____ (City) _____ (State) _____ (Zip)

_____ (Home Phone) _____ (Cellular Phone) ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widowed** ☐ **Other** (Marital Status)

_____ (Referring Physician) _____ (Phone) _____ (Fax)

Patient's Employment Information ☐ **Retired** ☐ **Student** ☐ **Self-Employed** ☐ **None**

_____ (Employer Name) _____ (Address) _____ (City) _____ (State) _____ (Zip) _____ (Phone)

Insured's Information ☐ **Please check here if subscriber is patient**

_____ (Name) _____ (Social Security #) _____ (DOB) ____ (Sex) _____ (Phone)

_____ (Employer Name) _____ (Address) _____ (City) _____ (State) _____ (Zip) _____ (Phone)

Emergency Contact Information

_____ (Emergency Contact Name) _____ (Phone Number) _____ (Relation to Patient)

YOU ARE RESPONSIBLE FOR THE UNPAID PORTION OF YOUR BILL. We will file your insurance.

A) By signing below I agree to the following:

1. **Authorization to Release Information:** I hereby authorize **Advanced Imaging Center of Amarillo** to release any information acquired in the course of my examination or treatment.
2. **Authorization to Obtain Prior Studies/Pertinent Information:** I hereby grant authorization to **Advanced Imaging Center of Amarillo** to request prior medical records/reports pertaining to this study from other imaging facilities I have been to in the past.
3. **Assignment of Benefits:** I hereby authorize payment to **Advanced Imaging Center of Amarillo** all benefits due, in any, by reasons of the services described in this statement. I will be responsible for any balance in whatever excess of whatever sums may be paid by my insurance company.
4. **Acknowledgement of Receipt of HIPAA/Privacy Notice:** I acknowledge that the privacy notice dated April 1, 2013 has been made available to me. Please Initial acknowledgement: X_____

Signature: X _____ Date: [Date] _____

B) Medicare/Medicaid Patients (Only)

1. I request that payment of authorized Medicare/Medicaid benefits be made on my behalf to **Advanced Imaging Center of Amarillo** for any services furnished me. I authorize any holder of medical information about me to release to the Center for Medicare & Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature of Cardholder: X _____ Date: [Date] _____