

## **Assured Imaging Office Headquarters:**

7717 N. Hartman Lane, Tucson, AZ 85743 Phone: 888.233.6121 Fax: 520.572.7138

## MRN: PATIENT INFORMATION AND ACKNOWLEDGEMENT FORM **Last Name First Name** МΙ DOB Sex Age $\square$ F $\square$ M Mailing Address City State Zip Code **Home Phone Alternate Phone Doctor Doctor Address Doctor Phone** Auto Accident or Workers Comp related? NO YES Do You Have Medicare? NO YES, # SELF-PAY receipt number: **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) Policy # **Insurance Company** 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: \_ 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. \_\_\_\_\_ 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

Patient/Parent/Legal Guardian Signature

Date: \_\_