ASSOCIATION OF
ALEXANDRIA
RADIOLOGISTS

PATIENT INFORMATION

Account #:_____ Date of Service:_____ Date of Birth:_____

Patient Name: _____
LAST FIRST MIDDLE

Address:_____
NUMBER & STREET CITY STATE ZIP

Phone Numbers: Home_____ Day Time_____ Cell_____

☐ Male ☐ Female E-Mail:_____

REFERRING PHYSICIAN INFORMATION

Referring Physician:_____
Address:_____
_____
Phone:_____
Fax:_____

CC Physician:_____
Address:_____
_____
Phone:_____
Fax:_____

INSURANCE - PRIMARY

Insurance:_____
ID/Policy #:_____ Group #:_____
Insured Name:_____
Date of Birth:_____ :_____

INSURANCE - SECONDARY

Insurance:_____ _____
ID/Policy #:_____ #:_____
Insured Name:_____
Date of Birth:_____ :_____

AUTHORIZATION AND AGREEMENT OF PAYMENT

I hereby certify that all of the above information is true. I agree to have medical information released for billing purposes to my insurance carrier and to billing personnel. I request that payment of authorized Medicare or other insurance benefits be made to either me or on my behalf to Association of Alexandria Radiologists, PC. I understand that I am responsible for knowing and understanding my insurance policy and benefits and that I am responsible for any copays, deductibles or services not covered by my insurance plan.

By signing below I consent to be contacted by regular mail, by e-mail or by telephone (including a cell phone number) regarding any matter related to the above referenced account by the creditor, its successors or assigns. This consent includes any updated or additional contact information that I may provide and includes contact that employs auto-dialer technology and/or prerecorded messages.

I permit a copy of this authorization to be used in place of the original.

_____ _____
Signature of Patient/Subscriber Date

WOMEN OF CHILDBEARING AGE (AGES 15-55) MUST COMPLETE THE FOLLOWING.

Are you pregnant? ☐ Yes ☐ No Date of last menstrual period_____

_____
Signature