SUMMIT radiology

Patient Information

Last Name: _____ **Mailing Address:** _____

First Name: _____ _____

Date of Birth: _____ _____

Home Phone: _____ Employer: _____

Cell Phone: _____ Employer Phone #: _____

Marital Status: _____

Emergency Contact

Name: _____ Home Phone: _____

Relationship to patient: _____ Cell Phone: _____

Insurance - Policy Holder's Information (if patient is under 18 years old)

Primary Insurance: _____

Policy Holder Name: _____ Address: _____

Date of Birth: _____ City/State/Zip: _____

Phone #: _____ Relationship to patient: _____

Secondary Insurance: _____

Policy Holder Name: _____ Address: _____

Date of Birth: _____ City/State/Zip: _____

Phone #: _____ Relationship to patient: _____

Release of Information and Payment Authorization

I authorize the release of information necessary to process this claim and assign benefits payable for services directly to Summit Radiology. I authorize the release of any medical information necessary for treatment by my current or future physician or health care provider. I authorize Summit Radiology to release to my insurance company, any medical information which may be necessary to process my insurance claim. I understand that in the event my insurance company denies the claim, I will be held financially responsible for all charges. I understand that if my services are related to an accident and an attorney or 3rd party are involved, I am still financially responsible for all charges incurred.

_____ _____ _____

SIGNATURE (patient name, or guardian name if a minor) **PRINT** (patient name, or guardian name if a minor) **DATE**

_____ **I acknowledge that I have received a copy of Summit Radiology Privacy Notice**

(Initials)

In the future if your records are needed, please list anyone authorized to pick them up: _____

(Example: mother's name, father's name, wife's name, husband's name, friend)

Your opinion matters! Tell us how we did: Please visit **www.summitrockford.com** and take our secure survey. Thank you!