Paesanos Parkway Imaging
Your Family Friendly MRI Facility
(210) 479-1966
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PAESANOS PARKWAY IMAGING - PATIENT INFORMATION FORM

Last Name:		First Name:		Middle Name:
PPI #:	DOB:	Age:	SSN:	Gender:
Address:				
City:		State:		Zip Code:
Home Phone:		Cell Phone:		Email:

EMERGENCY CONTACT INFORMATION

Name:	Relation:	Cell Phone:

Primary Insurance Information

Insurance Name:		Plan Name:
Policy #:	Group #:	
Policy Holder Name:	DOB:	Pt's. Relation to Policy Holder:

Secondary Insurance Information

Insurance Name:		Plan Name:
Policy #:	Group #:	
Policy Holder Name:	DOB:	Pt's. Relation to Policy Holder:

AUTO INJURY / WC INFORMATION

Is this visit related to an auto accident?	☐ Yes ☐ No	Date of Accident:
If Auto: Claim/Policy #:		
Is this visit for a work injury?	☐ Yes ☐ No	Date of Injury:
Claim #:	Adjustor Name:	Phone #:

OUT OF NETWORK INSURANCE

I am aware that PPI is out of network with my current insurance. I acknowledge that the insurance plan may therefore provide bennefits at the out of network benefit level. I understand that I am responsible for paying any remaining balance for these services. _____ Initials

ASSIGNMENT OF BENEFITS / FINANCIAL RESPONSIBILITY

- I, as patient or legal guardian of patient, consent to any services rendered on the instruction of the ordering physician.
- Payment is required at the time of service; if you supply all information needed today, we will bill you primary insurance. This does not waive your responsibility for payment. Remember whether you have health insurance coverage or not, professional services are rendered and charged to the patient. You (or the responsible party in the case of a minor) are responsible for payment of your bill even if not covered in full or in part by your insurance.
- PPI bills secondary insurances only as a courtesy. Any balance owed after secondary insurance will become my responsibility to pay.
- I will be responsible for late fees, collection charges or attorney fees incurred to obtain monies owed.
- I authorize this office to release information to pay physician/facility and/or insurance company for claims processing. I also authorize payment directly to Paesanos Parkway Imaging for any and all services I have received or may receive in the future of all benefits for which I may be eligible including but not limited to insurance benefits. This authorization in no way waives my responsibility for full payment for all services received. This authorization shall remain in effect until revoked in writing by me.
- I acknowledge that the only health insurance coverage I have is listed above.

TREATMENT CONSENT: I, as a patient or legal guardian of the patient, consent to the provision of any medically-necessary tests or procedures to be performed on this date, that my ordering physician, practitioner, or healthcare provider has ordered.

I have read and fully understand and agree to the above statement(s).

_____ _____

SIGNATURE (PATIENT / PARENT / LEGAL GUARDIAN/FINANCIALLY RESPONSIBLE PARTY **DATE**