SOUTH TEXAS RADIOLOGY IMAGING CENTERS

PATIENT INFORMATION (PLEASE PRINT)

LAST NAME	FIRST NAME	MIDDLE INITIAL

MAILING ADDRESS	APT #	CITY	STATE	ZIP CODE

HOME PHONE #	CELL PHONE #	WORK PHONE #	DATE OF BIRTH	SEX	SS#
( ) -	( ) -	( ) -	/ /	❒ M ❒ F	/ /

EMAIL	REFERRING PHYSICIAN	EXPLAIN CURRENT SYMPTOM(S) FOR THIS EXAM(S)

INSURANCE INFORMATION
A COPY OF YOUR INSURANCE CARD AND/OR PAYMENT WILL BE REQUIRED

1. PRIMARY INSURANCE	POLICY HOLDER	SS#
❒ SELF ❒ SPOUSE ❒ OTHER ❒ MOTHER ❒ FATHER	BILLING ADDRESS	
	POLICY ID#	GROUP / PLAN #

MEDICARE PATIENT ONLY: Are you currently participating in a Clinical Research Trial? ❒YES ❒NO

2. SECONDARY INSURANCE	POLICY HOLDER	SS#
❒ SELF ❒ SPOUSE ❒ OTHER ❒ MOTHER ❒ FATHER	BILLING ADDRESS	
	POLICY ID#	GROUP / PLAN #

3. WORKERS' COMPENSATION

EMPLOYER	EMPLOYER ADDRESS	WORK PHONE # ( )
W/C INSURANCE CARRIER	W/C INSURANCE CARRIER ADDRESS	CLAIM #
DATE OF INJURY	ADJUSTER'S NAME	ADJUSTER'S PHONE # ( )

INSURANCE ASSIGNMENT
I hereby consent to the release of information to my insurance carrier regarding my treatment at South Texas Radiology Imaging Centers (STRIC). I further authorize payment to be made directly to STRIC for any insurance benefits to which I am entitled.

STATEMENT OF FINANCIAL RESPONSIBILITY
I understand and agree that I am financially responsible for any and all charges for services rendered by STRIC regardless of the existence of a health plan or health insurance and assignment of insurance benefits. Many insurance companies have additional stipulations that may affect your coverage. I understand I am responsible for any amounts not covered by my insurer. If my insurance carrier denies any part of my claim, I will be responsible for the balance. STRIC bills secondary insurances only as a courtesy. Any balance not paid by secondary insurance will become my responsibility to pay.

RELEASE OF STRIC MEDICAL RECORDS TO HEALTH CARE PROVIDERS
I hereby consent and authorize STRIC to release any and all information in my medical records to my physician(s) and other health care providers involved in providing care to me.

RELEASE OF MEDICAL RECORDS TO STRIC
I hereby request and authorize my health care provider(s) to release to STRIC: medical records, x-ray films, reports and pathology results as needed in assisting STRIC in providing my medical consultation, care and/or treatment.

OUT OF NETWORK INSURANCE - ACKNOWLEDGEMENT OF POTENTIAL LIABILITY
I am aware that the STRIC facility where I am having services performed is not considered to be "In Network" with the third party insurance plan that provides my payment coverage. I acknowledge that the insurance plan may, therefore, provide benefits at the "Out of Network" level. I understand that I am personally responsible for paying any remaining balance due for these services. _____ Initials

X _____ _____
Signature of Patient/Legally Authorized Person/Financially Responsible Party — Date

_____ _____
PLEASE PRINT NAME — SS# (IF OTHER THAN PATIENT)