PATIENT INFORMATION

Last Name_____ First _____ Middle Int ____ M / F

Address _____ Apt. # _____

City _____ State/Zip _____ Home# _____

Cell# _____ Email _____

Date of Birth _____/_____/_____ Social Sec. # _____-_____ -_____

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Primary Insurance _____ Secondary _____

Name of Insured (if **other** than patient) _____

Insured's info Date of Birth: _____ Social Sec # _____-_____-_____

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ACCIDENT: Is this injury a result from an accident: Yes / No Auto _____ Work _____

Date of accident: _____/_____/_____ Claim number: _____

Auto Insurance: _____ Adjuster: _____

Attorney Name _____ Phone : _____

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How did you hear about Beaches? (Circle) Doctor Friend Online Insurance

By signature below, I understand that Beaches MRI (hereinafter BMRI) has agreed to provide me (patient or patient's guardian) with the important health care imaging service ordered by my doctor, even if my insurance company has denied, delayed or failed to authorize the service. I further recognize that BMRI will do everything possible with my doctor to convey the importance and necessity of the imaging service to my insurance company, but I understand and agree that I am ultimately financially responsible for any cost my insurance company denies or does not pay for any reason. In addition, I authorize payment of medical benefits directly to BMRI. This assignment includes but is not limited to all rights to collect benefits directly from my insurance company or HMO for those services I have received and all rights to proceed against my insurance company or HMO in any action including legal suit if for any reason my insurance company or HMO fails to make payments of benefits that are due to BMRI. This assignment also includes the right to recover any attorney fees and costs for such action brought by BMRI as my assignee. If I have requested that my insurance company hold my benefits for lost wages, I hereby release those amounts necessary to pay for services provided by BMRI. Furthermore, I direct my attorney to withhold funds and pay BMRI directly for the imaging services they have provided, from any recovery I may have. I understand that BMRI will file my insurance claim as a courtesy to me, and that any amounts not covered by my insurance will be paid by me. I authorize BMRI to release any and all information requested by any insurance company billed, in order to complete my insurance claim.

Signature:_____ Date: _____