

Marin Magnetic Imaging

PATIENT INFORMATION SHEET

Date of service: _____ MR: _____ CT: _____ Account number: _____

Patients Social Sec # _____ Date of Birth _____

Last name, First name _____

Mailing Address _____

City/Zip _____

Home phone: _____ work phone: _____

Employer: _____

Relationship to insurance card holder: SELF _____ Spouse: _____ Child: _____ Other: _____

If not self, Card Holders Name: _____

Industrial/Other insurance information: _____ (No need to complete if you bring your Insurance card with you.)

Name of carrier: _____

Address: _____

City/State/Zip: _____ Phone: _____

Claim # _____ Authorized by: _____

Date of injury/loss: _____ Employer at time of injury: _____

In order to have California Advanced Imaging (formerly Marin Radiology Medical Group, Inc) bill your insurance you must sign this release: I authorize the release of any medical information necessary to process an insurance claim and request payment under the medical insurance program be made either to me or to California Advanced Imaging on any bill for service furnished by that provider. I authorize payment of Medical Benefits directly California Advanced Imaging for services performed, and I understand that I will be responsible for all non-covered services because of lack of authorization, out-of-provider network expense, or any other reasons of denial. Further, by signing this, I acknowledge that I have received and reviewed the Notice of Privacy Practices. In addition, I agree to your use and disclosure of protected health information about me as described in our Notice of Privacy Practices.

X _____
signature/date

For office use:

Referring Physician: _____ Scan ordered: _____

Account Comment/Authorization Number: _____ Deposit: _____

CPT Code: _____ ICD.9 _____ ICD.9 _____ MD: _____

CPT Code _____ ICD.9 _____ ICD.9 _____ MD: _____