IMAGINGPARTNERS
Diagnostic Medical Imaging

PATIENT NAME:_____
LAST NAME FIRST NAME MIDDLE INITIAL

DOB: ___ /___ /_____ **PHONE:** ( ) _____ ( ) _____ **MALE / FEMALE** (circle)
Primary Secondary

ADDRESS: _____
STREET CITY STATE ZIP

PHYSICIAN'S NAME:_____**PHONE:**_____

PRIMARY INSURANCE NAME:_____

CLAIMS ADDRESS:_____
STREET CITY STATE ZIP

NAME OF INSURED: _____ **DOB:** ___ / ___ / _____ **RELATIONSHIP:** _____
(ONLY IF DIFFERENT THAN PATIENT NAME)

GROUP NUMBER: _____ **ID NUMBER:**_____

I hereby authorize and direct my insurance carrier to pay directly to MORAN, ROWEN & DORSEY, INC. any benefits due me under my insurance plan. I agree to pay the balance of expenses not paid under this plan. I authorize MORAN, ROWEN & DORSEY, INC to release to my insurance carrier any medical information necessary to process this claim.

POINT OF SERVICE PATIENTS: I understand that I may be responsible for any out of pocket expenses or co-pays if I am using my plans "Out of Network" benefit. I understand that benefits are based on my plan's guidelines.

AUTHORIZED SIGNATURE:_____**DATE:**_____ /_____ /_____

I hereby authorize the release and transporting of any of my diagnostic imaging exams between the clinical offices of MORAN, ROWEN & DORESY, INC. and the ST. JOSEPH HOSPITAL radiology locations.

AUTHORIZED SIGNATURE:_____**DATE:** _____ /_____ /_____

I understand that pre-authorization may be required for some procedures under my plan (such as MRI, CT or Ultrasound) and it is my responsibility through my referring physician to ensure pre-authorization is obtained prior to my scheduled appointment. I acknowledge this fact and agree that I will be financially responsible should my insurance carrier deny my claim for lack of a pre-authorization.

AUTHORIZED SIGNATURE:_____**DATE:** _____ /_____ /_____

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