Iowa Radiology- 2024

Due to changes in the United States Health Care Reform, we are now required to obtain additional information at the time of service.

Patient Name: _____Date of Birth: _____
Last First MI

Soc. Sec. #: _____ Marital Status: _____

Sex Assigned at Birth: M☐ F☐ X☐ Gender Identity: _____
(If different than birth gender)

Please circle one:
Caucasian Asian African American American Indian Hispanic Decline

Address: _____
Street/Apt # City State Zip

E-Mail Address: _____
If you give us your e-mail address, we will use it to communicate and confirm appointments.

Home Phone: _____ Cell Phone: _____ Work Phone: _____

PHYSICIAN INFORMATION: (Provider to receive copy of imaging report)

Referring: 1. _____ 2. _____

Have you had prior radiology services under a previous last name? If yes, please list: **_____**

Emergency Contact Information:

Name: _____Rel: _____ Phone #: _____

If Patient is a minor, please designate guarantor/responsible party information:

Name: _____ Rel: _____ Date of Birth: _____

PLEASE SELECT ONE OF THE FOLLOWING:

***Insurance policy is held by:**

Self/Patient*☐ Spouse*☐ Parent*☐ other*☐ No ins. / Self Pay*☐

*** If insured is someone other than self/patient, please complete the following:**

Primary INS: Name of insured person/employee: _____Insured's DOB: _____

Secondary INS: Name of insured person/employee: _____Insured's DOB: _____

Release of Records and Authorization of Insurance Benefits

I give Iowa Radiology the consent to treat me as a patient in this facility. I hereby authorize any medical facility to release my previous mammograms, films/images, and reports to Iowa Radiology for comparative purposes. In addition, I authorize Iowa Radiology to release my mammograms, films/images, and reports to any other facility for comparative purposes.

I give permission to release information requested by the insurance company to pay this claim. I hereby authorize payment directly to Iowa Radiology for all services provided. In making this authorization, I understand that I will be held responsible for any unpaid balances not covered by my insurance company. I assume and agree to be responsible for an administrative fee if my account enters a default status and is considered "past due".

I am aware that Iowa Radiology is participating in the clinical education of students attending Unity Point Des Moines School of Radiologic Technology; I consent to the receipt of services from students in the program. (Students will not be participating in clinical training in mammography or ultrasound).

Acknowledgement of Privacy Practice

□ I have been given a brochure on Notice of Privacy Practices.

□ I have declined a brochure on Notice of Privacy Practices.

**This authorization is good for one calendar year from the date signed below.

_____/_____/2024

Patient (or legal guardian) **Signature** **Date**

_____

Relationship (if not patient) Parent or legal guardian's date of birth