

# Iowa Radiology- 2022

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

## PATIENT INFORMATION

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Last First MI

Soc. Sec. #: \_\_\_\_\_ Sex: M \_\_\_\_\_ F \_\_\_\_\_ Marital Status: \_\_\_\_\_

Please circle one:

Caucasian Asian African American American Indian 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: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

## PHYSICIAN INFORMATION

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 Iowa Health 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).

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

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**Patient** (or legal guardian) **Signature** \_\_\_\_\_ / \_\_\_\_ / 2022  
**Date**

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Relationship (if not patient)

Parent or legal guardian's date of birth

### **Mammogram Patients Only**

If you need further work up following your screening mammogram, such as additional views or ultrasounds, we will contact you to schedule an appointment at our Diagnostic Center at 12368 Stratford Drive, Clive, Iowa.