

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 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.

_____/_____/2022
Patient (or legal guardian) Signature **Date**

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