# Iowa Radiology- 2023

*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.

_____/_____/2023

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

_____

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