



Patient Information

Name: _____ Sex: _____ Date of Birth: _____ Age: _____
Last First M.I. Mo / Day / Year

Address: _____ Home Phone: (____) _____
Street Number Apt. #

_____ Work Phone: (____) _____
City State Zip

Email Address: _____ Cell Phone: (____) _____

Social Security #: _____ If work related, injury date: _____

Referring Dr: _____ Phone #: _____ Employer: _____

Subscriber Information

Name: _____ Home Phone: (____) _____
Last First M.I.

Address: _____ Cell Phone: (____) _____
Street Number Apt. #

_____ Work Phone: (____) _____
City State Zip

Social Security #: _____ Employer: _____

Primary Insurance / Group Name: _____

Insurance billing address: _____ Birth date of insured: _____
Street Number

_____ Relationship to Patient: _____
City State Zip

ID #: _____ Group #: _____

Secondary Information

Secondary Insurance / Group Name: _____

Name of Insured: _____ SSN#: _____
Last First M.I.

Insurance billing address: _____ Birth date of insured: _____
Street Number

_____ ID #: _____ Group #: _____
City State Zip

Authorizations

I N S U R A N C E

I hereby authorize and direct my insurance carrier to pay directly to West Rad Medical Group any benefits due me under my insurance plan. I agree that should it be determined that I am ineligible or services are denied me under my Health/Insurance Plan, I will be responsible for payment to West Rad Medical Group for those services disallowed, ineligible, or not covered.

I authorize West Rad Medical Group to release to my insurance carrier any medical information necessary to process this claim. I understand that I may be responsible for any out of pocket expenses or co-pays if one or more of the following apply: Point of Service HMO

AUTHORIZED SIGNATURE: X _____ Date: _____

A C K N O W L E D G E M E N T S

I understand that pre-authorization may be required for some procedures. 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: X _____ Date: _____

If not patient, relationship: _____

West Coast Radiology Centers' "Notice of Privacy Practices" are posted and available upon request. **Initials:** _____