Date of Service	Appt. Time:	Pt. ID.	Acct #:

Procedure Ordered:

Referring Physician: Ref. Phy. Phone: Ref. Phy. Fax:

Ref. Phy. Address: City St. Zip

Last Name	First	MI	Gender
SSN	DOB	Marital Status	

Address1		
Address 2		
City	State	Zip

CONTACT

Day Phone
Evening Phone
Other
E-mail

RESPONSIBLE PARTY

Last Name	First	MI
SSN	DOB	Relationship
Address		
City	State	Zip
Phone	Employer	

EMERGENCY

Name
Relation
Phone

BILLING INFORMATION SELF PAY ☐ INSURANCE ☐ DIRECT BILL ☐

Payer Name		Plan Name	
Address			
City	State	Zip	Phone
Subscriber Relationship	Last	First	MI
DOB	Policy #	Group #	

Consent to Procedure: The undersigned patient/ responsible party consents to the imaging procedure(s) listed above ordered by my physician. **Financial Responsibility**: By accepting any medical service or treatment, including but not limited to the above listed procedure(s), the undersigned patient/ responsible party agrees to pay Brookwood Diagnostic Centers, all charges for such service or treatment. Your insurance is filed as a courtesy to you. All co-pays, deductibles, co-insurance, previous balances, and fees for non-covered services are due at the time of your visit. We will be happy to provide you with a statement of your account, when requested, to file with a secondary or tertiary insurance, once your account is paid in full. We will file secondary insurances, when needed, if required by a specific contract. If you are a Medicare recipient, we will file your Medicare as required for participation in the Medicare program.

We will provide the best possible care for you. Services we provide to you may or may not be covered by your insurance due to routine, non-covered, or “deemed medically unnecessary” by your insurance company, In the event your insurance company does not cover your services, you will be responsible. We will make every effort to let you know if we feel your insurance company may not cover your services. You are responsible for knowing the benefits/ coverage of your insurance.

Signature:______________________________________

I agree that the above information is true and accurate.

Are you currently involved in a clinical Trial Study? Yes_____ No_____

Signature____Date_________________________