

Social Security Number \_\_\_\_\_ Date of Injury or Illness \_\_\_\_\_  Male  Female

First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Last Name \_\_\_\_\_ Title \_\_\_\_\_

Date of Birth \_\_\_\_\_ Current Age \_\_\_\_\_ Marital Status:  Married  Single  Divorced  Widowed

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_ Cellular Phone # \_\_\_\_\_ E-mail Address \_\_\_\_\_

Patient's Employer \_\_\_\_\_ Employers Address, City, State and Zip Code \_\_\_\_\_

Student:  Yes  No If yes: School Name \_\_\_\_\_ School Address, City, State and Zip Code \_\_\_\_\_

Emergency Contact Name(s) \_\_\_\_\_

Relationship \_\_\_\_\_ Home Telephone Number \_\_\_\_\_ Work Telephone Number \_\_\_\_\_

Present Complaint \_\_\_\_\_

Are you a resident of a nursing home or an assisted living facility?  Yes  No

If yes, which one? \_\_\_\_\_

Insured's Name (as it appears on insurance card) \_\_\_\_\_

Insured's Date of Birth \_\_\_\_\_

**LIST ANY PERSONS TO WHOM YOU WILL ALLOW ACCESS OF YOUR MEDICAL RECORDS**

Name/Contact Information: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Name/Contact Information: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

By signing this form, I hereby acknowledge receipt of the "Notice of Privacy Practices".

Signature of Patient \_\_\_\_\_ Signature of Responsible Party \_\_\_\_\_ Date: \_\_\_\_\_

**PLEASE GIVE ALL INSURANCE CARDS TO RECEPTIONIST  
RELEASE OF INFORMATION, BENEFIT ASSIGNMENT, PAYMENT AUTHORIZATION,  
FULL DISCLOSURE AND AGREEMENT TO PAY FOR PROFESSIONAL SERVICES.**

I hereby authorize Carmichael Imaging, LLC/MBC to release any information necessary to process any insurance claim acquired in the course of my examination or treatment to allow a photocopy of my signature to be used to process my insurance claim. I claim, direct, and authorize my carrier to issue payment check(s) directly to Carmichael Imaging, LLC for any insurance benefits to which I am entitled. I understand that failure to disclose precertification/second opinion requirements for any and all plans to which I subscribe may cause me to incur full liability for professional charges as a result of non-payment by my carrier. Regardless of insurance benefits, if any, I understand that I am fully responsible for any and all fees incurred and I agree the above is a legal and lawful debt. If it becomes necessary to forward this account to collections, I agree to be responsible for any/all collection costs, attorney fees and/or court costs. I realize that in extraordinary circumstances, some insurance companies will not pay for certain procedures (i.e. MRI's or Ultrasounds). I understand that my insurance is filed as a courtesy and I am responsible for the bill. I, the undersigned, give CI/MBC, its employees and/or agents "express prior consent" to contact me at any/all phone numbers, including cell phone numbers (by phone call or text message) for the purpose of treatment, insurance and/or payment.

I authorize Carmichael Imaging/Montgomery Breast Center to obtain my medical records from my referring physician to use in the processing of the charges for my visit. I also hereby authorize Carmichael Imaging/Montgomery Breast Center to request release of other previous imaging studies and/or other medical information taken at another institution. This authorization shall remain valid until revoked by me.

Patient/Responsible Party Signature \_\_\_\_\_ Date \_\_\_\_\_

Payment of co-payment is expected at the time of service.  Check  Credit Card  Cash