Reston Radiology Consultants

Patient Information Questionnaire

Patient's Legal Name (L, F, MI)			Date:
Patient's Legal Address:	City/State/Zip		Home Phone:
E-Mail:		DOB:	Sex:
Social Security #:		Marital Status:	
Employer:		Occupation:	
Work Phone:	Referring Physician:		Date of Onset:
Symptoms:		Have you had prior studies here?	

Responsible Parties Information (*If Different From Patient)*

Responsible Party:	Relationship	DOB:
Social Security #:	E-Mail:	
Responsible Parties Address:	City/State/Zip	Home Phone:
Employer:		Work Phone:

Insurance

Primary Insurance Company:	ID Number:	Group #:
Insured:	Employer:	
Relationship to Patient:	Treatment Authorization:	
Secondary Insruance Company:	ID Number:	Group #:
Insured:	Employer:	
Relationship to Patient:	Treatment Authorization:	

Authorization and Assignment

I certify that the information I have reported with regard to insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim in order to determine benefits, which I may be entitled. I permit a copy of this authorization to be used in place of the original.

I hereby authorize payment directly to the facility for benefits or otherwise payable to me under the terms of my policy but not to exceed my indebtedness to said physician for services as described hereon. In making this assessment to the physician, I understand and agree that any unpaid balance not covered by this policy will be billed to me.

I acknowledge that I have received the Reston Radiology Consultants HIPAA Notice of Privacy Practices.
I give my permission for release of my medical information to the following individuals:

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_____

Signature of Subscriber/Beneficiary Date