6300 St. Johns Ave
Palatka, FL 32177
P: 386-280-0080
F:386-280-0081

PATIENT INFORMATION

Last Name:_____ First: _____ Middle: _____

Date of Birth:_____ Sex: _____ SSN: _____

Mailing Address: _____

City:_____State:_____ Zip Code:_____

Home Phone: _____ Cell: _____

Email:_____

_____ ***By placing my initials in the space provided, I verify that I have reviewed the information above and it is correct.***

PRIMARY INSURANCE

Plan: _____ Policy #:_____

Group #: _____ Policyholder's Name: _____

Policyholder's Relationship to Patient: _____ Policyholder's DOB: _____

SECONDARY INSURANCE

Plan: _____ Policy #:_____

Group #: _____ Policyholder's Name: _____

Policyholder's Relationship to Patient: _____ Policyholder's DOB: _____

ACKNOWLEDGEMENT / WAIVER OF LIABILITY

Please initial by each statement below:

_____ I hereby authorize Express Medical Imaging to bill my insurance carrier (s) for services rendered. I further authorize the release of all necessary information including reports, images and outcomes as requested by Insurance Carrier(s).

_____ I understand that charges for all services provided, but not covered by my insurance carrier(s) will be my financial responsibility.

_____ I authorize the release of all or any portion of my medical record to any health care practitioner or facility designated by me. *Image reports will automatically be sent to the ordering physician's office. If you would like this report to be sent to another facility please specify.

_____

Patient or Parent/Guardian Signature: _____ Date: _____

EXPRESS MEDICAL IMAGING

6300 St. Johns Ave
Palatka, FL 32177
P: 386-280-0080
F:386-280-0081

Billing Insurance

We will file your insurance as a courtesy. If your insurance carrier denies your claim, you are responsible for the bill.

When you receive a bill from Express Medical Imaging, it indicates that your insurance company has finished processing your claim and has paid its share of the bill.

The explanation of benefits or request for information letter you receive from your insurance company will help you understand why you have received a bill from Express Medical Imaging. Carefully review the bill along with its explanation from your insurance company. This will show your deductible (if you have one), how much of your deductible you have paid, the co-pay you are responsible for, any charges not covered by your insurance that you are responsible for, and your current coverage details.

Your health insurance policy is a contract between you and your insurance company. For your benefit, please take the time to understand your policy. There are too many different insurance plans for Express Medical Imaging (any outpatient practice) to know all the specific details of each plan.

Remember that your insurance company, not Express Medical Imaging, makes the decision about what will and what will not be paid/covered.

Out of date care, incorrect cards and any incorrect information can cause unnecessary delays in the payment of your claim and the balance may ultimately become your full financial responsibility.

Time of service payment, such as copays or coinsurance, is not always your full patient responsibility. You are ultimately responsible for any balance remaining on the account after your insurance has paid or total charges even if the insurance is pending or denied.

In the event payment is not received, Express Medical Imaging may send the account to a third-party collections agency. You will be required to reimburse Express Medical Imaging the fees of any collection agency, which may be based on a percentage at a maximum of 50% of the debt, and all costs, and expenses, including reasonable attorneys' fees, we incur in such collection efforts.

I have read the above information and understand it.

_____ _____

Patient/Guardian Signature Date

EXPRESS MEDICAL IMAGING

6300 St. Johns Ave
Palatka, FL 32177
P: 386-280-0080
F:386-280-0081

PRIVACY PRACTICES RECEIPT ACKNOWLEDGEMENT

I acknowledge and agree to adhere to the notice of privacy practices as required by federal and state laws. I understand that I may request and review a copy of these practices at any time from the office staff.

_____ _____
Printed Name Date of Birth

_____ _____
Signature Date

Please list the following people that you give Express Medical Imaging permission to release your detailed medical information to. If you choose not to release your medical information, please write NONE below. (Please print)

Name: _____

Name: _____

EMERGENCY CONTACTS

Please list at least one person that we may contact in the event of an emergency. (Please print)

Name: _____

Relationship: _____Phone: _____

Name: _____

Relationship: _____Phone: _____