SUMMIT
RADIOLOGY SERVICES P.C.

WELCOME TO OUR OFFICE !

ROBERT KIM, M.D. MARK RHEAUME, M.D.

LAST NAME:_____ FIRST NAME:_____ M.I. _____

ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

HOME PHONE:_____ CELL:_____ WORK:_____

SSN:_____ DATE OF BIRTH:_____ MALE_____ FEMALE _____

EMAIL:_____

EMPLOYER:_____ OCCUPATION:_____

EMERGENCY CONTACT:_____ RELATIONSHIP:_____

EMERGENCY CONTACT PHONE:_____ PRIMARY CARE PHYSICIAN:_____

MARITAL STATUS: MARRIED___ DIVORCED ___ WIDOWED ___ SINGLE ___ SEPARATED___

SPOUSE NAME: _____ DATE OF BIRTH: _____

SPOUSE EMPLOYER:_____ EMPLOYER PHONE: _____

PRIMARY INSURANCE COMPANY:_____ SUBSCRIBER: SELF__ SPOUSE__ OTHER__

SECONDARY INSURANCE COMPANY: _____ SUBSCRIBER: SELF__ SPOUSE__ OTHER__

PLEASE NOTE: We will bill your secondary insurance as a courtesy. If claims are not paid within 60 days the balance will billed as patient responsibility.

My signature below indicates that I have been given the chance to read and review the following and understand and agree to their terms:

Patient Acknowledgement form
Financial and Office Policies form
Health Information Disclosure form
Notice of Privacy Practices (located in waiting room)

I agree the above information is true and I authorize Summit Radiology Services, PC to use this information to obtain financial reimbursement. I further authorize the release of any medical information necessary to process my insurance claim(s) and request payment of medical services to be assigned directly to Summit Radiology Services, P.C. In the event my insurance does not cover services rendered, I agree to be fully and personally responsible for payment. This authorization is to remain in effect unless I revoke the same in writing.

Patient Signature:_____ Date: _____

PATIENT ACKNOWLEDGEMENT FORM

I understand that the patient's health information is private and confidential. I understand that Summit Radiology Services, P.C. works diligently to protect the patient's privacy and preserve the confidentiality of the patient's personal health information.

I understand that Summit Radiology Services, P.C. may use and disclose the patient's personal health information to help provide health care to the patient, to assist with processing insurance billing and payments as well as other necessary health care operations. Patient's personal and confidential information will not be used or disclosed unless permitted by the patient in writing. I acknowledge that I understand that I have the right to read the "Notice of Privacy Practices" before signing this acknowledgement.

Summit Radiology Services, P.C. may update their Notice of Privacy Practices and this acknowledgement. I understand I may request a copy of the updated Notice of Privacy Practices.

Summit Radiology Services, P.C. adheres to strict policies to maintain proper use of patient information and maintain patient confidentiality. These policies may require written releases from the patient for medical records, charges for copies of records, authorization and reasonable time frames for requesting such information.

Summit Radiology Services, P.C. Notice of Privacy Practices contains a complete description of my privacy and confidentiality rights.

I acknowledge I have been given the opportunity to read and understand this policy prior to signing.

PATIENT NAME (PRINT):_____

PATIENT SIGNATURE:_____ DATE:_____

AUTHORIZATION TO DISCUSS OR DISCLOSE HEALTH INFORMATION

I authorize Summit Radiology Services, P.C. to discuss and / or disclose my health information with the following person / persons listed below:

1._____

2._____

3._____

I understand that information released may include any and all treatment plans, current health conditions, medication issues, history of health conditions, diagnosis, and diseases.

The following information is not allowed to be released:

PATIENT NAME:_____

DATE OF BIRTH:_____ SSN:_____

PATIENT SIGNATURE:_____ DATE:_____

WITNESS:_____ DATE:_____

THIS AUTHORIZATION FORM SHALL REMAIN IN EFFECT UNTIL REVOKED IN WRITING BY THE PATIENT.