

INFORMATION REQUIRED FOR CASE HISTORY FILE (PLEASE PRINT)

1. Male Female Primary Care Physician _____
Referring Physician _____
_____ Weight _____
Patient's Last Name First Middle
Birth Date _____ Age _____ Social Security Number _____
Address _____
City _____ State _____ Zip _____ Home Phone _____
Employer _____ Work Phone _____

2. What are your symptoms: _____

3. **Medical Coverage Information – Please Present Your Insurance Card**

Primary Insurance Co _____ **ID#** _____ **Group#** _____
Subscriber's Name _____ Birth Date _____ Male Female
Subscriber's Employer _____

Secondary Insurance Co _____ **ID#** _____ **Group#** _____
Subscriber's Name _____ Birth Date _____ Male Female
Subscriber's Employer _____

4. **Were you Injured.....** at work automobile accident other accident/injury*

Date of Injury _____ Claim# (if known) _____
Insurance Carrier _____ Adjuster _____
Address _____ Phone Number _____
Employer when injured _____ Phone Number _____
(Required for Worker's Compensation only)

*Briefly explain "Other" accident/injury _____

5. **Responsible Party for Patient under 18 Years of Age**

Name _____ Birth Date _____ Male Female
Relationship _____ Social Security Number _____ Home Phone _____
Address _____ City _____ State _____ Zip _____
If different from above

Employer _____ Work Phone _____



I HEREBY AUTHORIZE MY REFERRING PHYSICIAN TO RELEASE ALL MEDICAL INFORMATION NECESSARY TO COMPLETE MY MEDICAL CARE.

I HEREBY AUTHORIZE THE RELEASE OF ALL MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM.

I HEREBY AUTHORIZE PAYMENT OF MEDICAL BENEFITS DIRECTLY TO THE PHYSICIAN OR SUPPLIER OF SERVICES ITEMIZED ON SAID CLAIM.

I UNDERSTAND THAT FEES ARE SUBJECT TO CHANGE BASED ON ACTUAL EXAM(S) PERFORMED.

I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY CHARGES OR CHARGE BALANCES NOT PAID BY MY INSURANCE AND AGREE TO PAY THESE AMOUNTS.

I UNDERSTAND THAT THE RAS STANDARD OF CARE FOR MAMMOGRAMS INCLUDES AN ADDITIONAL READING USING COMPUTER-AIDED DETECTION (R2-CAD). I UNDERSTAND THAT I MAY INCUR AN ADDITIONAL COST BASED ON MY INSURANCE COVERAGE(S).

I UNDERSTAND THAT CHARGES FOR A SCREENING BREAST ULTRASOUND MAY NOT BE COVERED BY MY INSURANCE AND AGREE TO PAY THESE AMOUNTS. _____
INITIALS

I UNDERSTAND THAT I MAY INCUR ADDITIONAL COST BASED ON MY INSURANCE COVERAGE(S) FOR DIGITAL MAMMOGRAPHY AND AGREE TO PAY THESE AMOUNTS. _____
INITIALS

I UNDERSTAND THAT IN THE EVENT LEGAL ACTION SHOULD BECOME NECESSARY TO COLLECT AN UNPAID BALANCE DUE FOR MEDICAL SERVICES RENDERED, I AGREE TO PAY FOR REASONABLE ATTORNEY FEES OR OTHER SUCH COSTS AS THE COURT DETERMINES PROPER.

I HEREBY ACKNOWLEDGE THE RECEIPT OF A COPY OF THE RAS NOTICE OF PRIVACY PRACTICES. _____
INITIALS

Date

X _____
Patient/Responsible Party