ARCADIA RADIOLOGY
MEDICAL GROUP

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Main (626) 445-4850
Mammo (626) 821-8146
Fax (626) 821-3460

PATIENT INFORMATION FORM

Patient Name _____ ☐ M ☐ F
First Middle Last

SSN _____ D.O.B. _____ Main Phone ( ) _____ Second Phone ( ) _____

Address _____ City _____ State _____ ZIP _____

Emergency Contact _____ Phone ( ) _____

Referring Doctor _____

INSURANCE INFORMATION

PLEASE PRESENT YOUR INSURANCE CARD OR INFORMATION EACH TIME YOU VISIT OUR OFFICE
YOU ARE PERSONALLY RESPONSIBLE FOR ANY CO-PAY AND/OR DEDUCTIBLE DUE AT TIME OF SERVICE

PRIMARY INSURANCE

Circle One: Medicare / Medi-Cal / PPO / HMO

Insurance Name _____

Subscriber's Name _____ **D.O.B.** _____

SECONDARY INSURANCE

Circle One: Medicare / Medi-Cal / PPO / HMO

Insurance Name _____

Subscriber's Name _____ **D.O.B.** _____

PATIENT AUTHORIZATION & RELEASE

I, the undersigned certify that (I or my dependant) have insurance coverage and agree to assign Arcadia Radiology Medical Group all insurance benefits for services rendered. I authorize the use and disclosure of all medical records necessary for the purpose to secure payment of services. I understand that I am financially responsible for all charges.

Signature _____ Date _____

NOTICE OF PRIVACY PRACTICES: ACKNOWLEDGEMENT OF RECEIPT

I acknowledge receipt of Arcadia Radiology Medical Group's Notice of Privacy Practices. I understand that this document provides an explanation of the ways in which my health information may be used or disclosed by Arcadia Radiology Medical Group and of my rights with respect to my health information. I have been provided the opportunity to discuss my concerns I may have regarding the privacy of my health information.

Signature _____ Date _____

UNDER 18, SIGNATURE OF PARENT OR GUARDIAN IS REQUIRED.

☐ Parent ☐ Guardian ☐ Other _____

Signature _____ Date _____