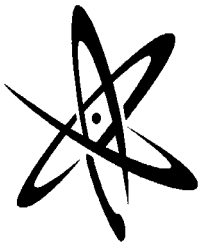

**Mobile Molecular Imaging**℠

**Please Print Clearly** **Date:** _____

## Patient Information

Name _____ SS#_____
Last First Initial

Address_____
City State Zip Code

Sex: M F Birthdate:_____ Age:_____ Home Ph: ( )_____

Occupation:_____

Employer:_____ Work Ph: ( )_____

Referred by Dr.:_____ Cell Ph: ( )_____

## Responsible Party Information

Responsible Party: _____ Relationship:_____
Last First Initial

Address _____

Home Phone: ( )_____ Driver's Lic.#_____ Cell Phone ( )_____

SS#:_____ DOB:_____ Employer:_____

Occupation:_____ Business Phone: ( )_____ Ext.:_____

## Insurance Card Holder Information

Insurance Card Holder: _____
Last First Inital

Date of Birth: _____ Relationship:_____

Occupation:_____ Employer:_____

Business Phone: ( ) _____ Ext.: _____

Emergency Contact: _____

Home Phone: ( )_____ Work Ph: ( )_____ Cell Phone ( )_____

## Financial Obligation

You are responsible for the payment of the charges for the health care that we provide. Unless your health insurance company, HMO, Medicare or Medicaid agreement with Mobile Molecular Imaging prohibits it, payment is due on the date of your appointment. We accept Visa, MasterCard, Discover and American Express and personal checks. Patients that do not have health benefits through a third party such as Medicare, Blue Cross Blue Shield or United HealthCare may speak to one of our Patient Service Representatives if you have any questions regarding our fees. Please ask the receptionist if you would like to see a Patient Service Representative.

## Assignment of Insurance

Some insurance companies require the assignment of insurance benefits for direct payment to Mobile Molecular Imaging. The undersigned hereby authorizes direct payment and assignment of any hospital insurance, medical insurance, sickness or injury benefits to Mobile Molecular Imaging, L.L.C. I understand that efforts for collection of these benefits are for my convenience and do not represent a guarantee of collection or credit to my account until such time as payment is received by Mobile Molecular Imaging, L.L.C.

## HIPAA Privacy Notice

I acknowledge that I have been provided with Mobile Molecular Imaging's Notice of Privacy Practices for protection of health information. Details regarding the protection of patient privacy are detailed on that document.

I acknowledge that I am responsible for the financial obligation arising from the provision of care to myself, or the person for whom I am acting as a personal representative (such as an unemancipated minor). I acknowledge that I will incur the reasonable costs of collections including attorney's fee should I fail to satisfy my financial obligation.

Signature of Patient or Authorized Representative Date _____

_____

Signature of Insured Date _____

_____