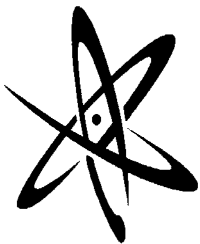

Please Print Clearly

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 ____________________

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Signature of Insured Date ____________________

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