# diagnostic health

PATIENT INTAKE FORM				
PATIENT INFORMATION		Patient MRN	N#:	
Last Name:	First Name:		_ MI: Gender: M / I	
Marital Status: S M D W DOB:	SSN:	County:	Race:	
Address:	City:	;	State: Zip:	
Home Phone:	_Mobile/Other:	Date of onset of pain of	or injury:	
May we send you an email to follo PATIENT EMPLOYER INFO	w up on the quality of service we	provide today? Y/N Email		
Status: Full Time Part Time Un-Em		Date of Retirement:		
Employer:	Work H	Work Phone: Extension:		
Employer Address:	NFORMATION			
Name:		Relationship to pa	atient:	
RESPONSIBLE PARTY (Con				
Name:	SSN:DO	DB: Relations	hip to Patient:	
Address (if different from patient): <b>PRIMARY INSURANCE INF</b>				
Insured Name:	DOB:	Relationship	to Patient:	
Insured Employer:	Address:		Ph#:	
On the Job Injury: Y/N Motor Vehi	cle Accident: Y/N Date of Acciden	nt/Injury: S	tate accident occurred:	
Group Name or Number:	Policy #	: Subscrit	er ID:	
Insurance Company Name & Addre	ess:		_Phone#:	
Worker's Comp Claim #:		nd Phone:		
SECONDARY INSURANCE				
Insured Name:	DOB: _	Relationship	to Patient:	
Insured Employer:	Address:		Ph#:	
On the Job Injury: Y/N Motor Vehi	cle Accident: Y/N Date of Acciden	nt/Injury: Sta	ate accident occurred:	
Group Name or Number:	Policy #	: Subscrib	er ID:	
Insurance Company Name & Addre	258:		_Phone#:	
Worker's Comp Claim #: I have reviewed the above inform	Adjuster Name ation and verify that it is accura	and Phone:ate.		
Patient Signature:	·		Date:	
Diagnostic Health Signature:			Date:	

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#### PHYSICIAN ORDER (Verbal Only)

Ordering Physician:	Caller Name:	
Verbal Order / Procedure(s):	Date:	

Signs & Symptoms (No Rule Out): \_\_\_\_\_

Verbal Order Received By: \_\_\_\_

## ASSIGNMENT OF BENEFITS AND FINANCIAL AGREEMENT

I understand if I have provided complete and accurate information, Diagnostic Health will file both my primary and secondary insurance. I understand based on the agreement Diagnostic Health has with my insurance network and information they have received at the time of verification my co-pay/co-insurance amount due today is \$\_\_\_\_\_\_. I also agree to be responsible for any additional co-share and or non paid amounts identified by my insurance after my claim has been processed. In the event legal action should become necessary, I agree to be financially responsible for all collection, attorney and court fees incurred.

I understand if the services provided today are being represented by an attorney, auto insurance and or third party payor, I am financially responsible for all charges incurred.

I authorize Diagnostic Health to release to my insurance company any medical information which may be necessary for processing my insurance claim. I also assign "benefits payable to" for my services today to Diagnostic Health.

I further authorize the release of any medical information in regard to the services which are provided by Diagnostic Health to any physician or health care provider by whom I have been or will be treated who request such information.

Scheduled Procedure(s):	Cost of Procedure(s): \$
Patient/Guardian Signature:	_ Date:
Diagnostic Health Signature:	_ Date:

## MEDICAL RECORDS AUTHORIZATION TO DISCLOSE

I authorize the disclosure of my medical records/information (individuality identifiable health information) to the persons listed below. I understand this is a voluntary request to release my health information to someone other than healthcare providers. I understand **only** the individuals identified below are authorized to receive copies, pick up my medical records or inquire about my account at Diagnostic Health (this includes my spouse, parents, family members, friends, children etc.). I also understand identification confirmation for any requesting individual will be confirmed and documented prior to the release of my record information.

1\_\_\_\_\_2\_

• Can Diagnostic Health leave information related to your account, appointment and or any other medical record information on your answering machine or voicemail? YES or NO (please circle)

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I understand this <u>Medical Records Authorization to Disclosure</u> will expire SIX Years from today. I understand I can revoke this authorization at any time by notifying Diagnostic Health in writing. If I revoke this authorization, Diagnostic Health will not be liable for any release of records completed prior to my change of this authorization. My signature below confirms that I understand and agree to the above statements regarding Medical Records Authorization to Disclose.

Signature of patient, responsible party or patient's representative

Date

Printed name for patient's representative (if applicable)

Relationship to patient (if applicable)

Diagnostic Health Representative Signature

Date