RADIA®

PATIENT INFORMATION

Name: _____ SSN: _____

Date of Birth (MM/DD/YY): _____ Gender: ☐ Male ☐ Female

Address: _____
(Street) (City) (State) (Zip Code)

Home Phone: _____ Alternate Phone: _____

Employer: _____ Work Phone: _____

Emergency Contact: _____ Phone: _____

Referring Physician: _____ Primary Care Physician: _____

Was this due to an injury? ☐ Yes ☐ No

Date of Injury: _____

Was this Injury? ☐ Work Related ☐ Auto ☐ Other: _____

RESPONSIBLE PARTY INFORMATION

Name (if different than patient): _____ SSN: _____

Relationship to Patient: _____ Date of Birth (MM/DD/YY): _____

Address (if different than patient): _____

Employer: _____

Primary Insurance: _____ Subscriber #: _____ Group #: _____

Secondary Insurance: _____ Subscriber #: _____ Group #: _____

TREATMENT: I hereby authorize employees of Radia to perform medical services ordered by my physician named above. I understand that further tests may be needed for clinical indications that may arise.

RELEASE OF HEALTH INFORMATION: I hereby authorize to release to third party payors (or any third party payor program I apply for) information about services as may be necessary for payment of my Radia bill. I understand that that these records may contain other information regarding previous medical history including, but not limited to psychological service, HIV, sexually transmitted diseases, or drug and alcohol issues, and hereby authorize their release (Patient/Guardian initials)_____.

FINANCIAL AGREEMENT: I hereby authorize payment directly to Radia for those insurance benefits otherwise payable to me for services provided on this day. Radia does not accept responsibility for negotiating settlement on a disputed claim and will not await payment/resolution from third party liability carriers, or from a carrier with whom Radia does not hold a contract for this date of service. I understand all charges are due in full and payable within 30 days from date of service unless a separate payment arrangement has been approved and signed by both Radia and myself.

_____ _____
Signature - Patient/Parent, if Patient is not of legal age (age 18) or legal guardian ***Date***

Affix patient sticker