PATIENT INFORMATION SHEET

______________________________ **First Name**

_________ **MI**

______________________________ **Last Name**

______________________________ **Date of Birth**

__________ **Current Age**

Male ________ Female ________

______________________________ **Marital Status**

______________________________ **E-Mail Address**

______________________________ **Address** **City** **State** **Zip Code**

___________________________ **Home Phone Number**

______________________________ **Cellular Phone Number**

______________________________ **Social Security Number**

______________________________ **Patient's Employer**

______________________________ **Employers Phone Number**

______________________________ **Emergency Contact Name(s)**

_______________________ **Relationship**

______________________________ **Home Phone Number**

______________________________ **Cellular Phone Number**

______________________________ **Referring Physician**

______________________________ **Physician's Phone Number**

PLEASE GIVE ALL INSURANCE CARDS TO RECEPTIONIST

RELEASE OF INFORMATION, BENEFIT ASSIGNMENT, PAYMENT AUTHORIZATION, FULL DISCLOSURE AND AGREEMENT TO PAY FOR PROFESSIONAL SERVICES

GUARANTOR OF ACCOUNT

I hereby authorize **Homosassa Open MRI** to release any information necessary to process any insurance claim insurance claim acquired in the course of my examination or treatment and to allow a photocopy of my signature to be used to process my insurance claim. I claim, direct, and authorize my carrier to issue payment directly to **Homosassa Open MRI,** for any insurance benefits to which I am entitled. I understand that failure to disclosure pre-certification/second opinion requirements for any and all plans to which I subscribe my cause me to incur full liability for professional charges as a result of non-payment by my carrier. Regardless of insurance benefits, if any, I understand that I am fully responsible for any and all fees incurred and I the undersigned, accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all collection agency fees, attorney fees and/or court costs, if such be necessary. I waive now and forever my right to exemption under the laws of the constitution of the State of Florida and any other State. I realize that in extraordinary circumstances, some insurance companies will not pay for certain procedures. I understand that my insurance is filled as a courtesy and I am responsible for the bill.

______________________________ **Patient/Responsible Party Signature**

______________________________ **Date**

You agree, in order for us to service your account or to collect monies you owe, **Homosassa Open MRI and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending emails, using any email address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing devices, as applicable.

I/We have read this disclosure and agree that **Homosassa Open MRI,** its employees and/or agents may contact me/us as described above.

______________________________ **Patient/Responsible Party Signature**

______________________________ **Date**

Deductible/co-pay is expected at the time of service. **Check ____ Credit Card ____ Cash ____**