Women's Healthcare Imaging, Corp.

1896 Morris Avenue Union, NJ 07083

Phone (908) 964 - 0004 Fax (908) 964 - 0034

ACCOUNT#________________

Patient Information

Name (Last, First, MI): Mr. / Mrs. Ms.	SS #:	Date of Birth:	Age:	Home phone:
Address:	City:	State:	Zip code:	Cell phone:
Employer:	City:	State:	Zip code:	Work phone:
Ethnicity (Please Circle): Asian Black Hispanic White	E-mail:			
Marital Status Single Married Divorced Widow	How did you hear about us (please let us know0 Doctor Friend Family Member TV Ad Newspaper			

Referring Doctor

Name:	Address:	Phone:	Fax:

Responsible Party if Patient is a Minor

Name (Last, First, MI):	Relationship to Patient:	SS #:	Date of Birth:	Age:	Home phone:

Insurance Information

Primary Insurance:	Subscriber Name:	Relationship:	Policy # / Group #:	Copay Amount:
Secondary Insurance:	Subscriber Name:	Relationship:	Policy # / Group #:	Copay Amount:

Emergency Contact Information

Contact name:	Relationship:	Primary phone #:	Secondary phone #:

Patient Release:

I hereby authorize and direct my insurance carrier to pay directly to **Women's Healthcare Imaging, Corp**. any benefits due me under my insurance plan. I agree to pay the balance of expenses not paid under this plan.

I also authorize **Women's Healthcare Imaging, Corp.** to release to my insurance company any medical information necessary to process this claim.

I assign **Women's Healthcare Imaging Corp.** all my rights and benefits under any insurance contracts for payment for services rendered to me by **Women's Healthcare Imaging, Corp..**

I furthermore and additionally authorize **Women's Healthcare Imaging Corp.** to file insurance claims on my behalf for services rendered to me as a result of an Automobile Accident/Workman's Compensation/Personal Liability claim, including filing arbitration and litigation. I direct all such payments to go directly to **Women's Healthcare Imaging, Corp..**

I authorize **Women's Healthcare Imaging, Corp.** to act on my behalf. You are responsible for your co-pay at the time of service. We are required by law to maintain the privacy of and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA compliance Officer in person or by phone at our main phone number. Signature is only acknowledgement that you have received this notice of our Privacy Practices.

I hereby give permission to contact my Physician or Health Care facility to obtain prior reports or films/ imaging studies relating to prior exam.

I acknowledge that I have received a copy of THE BILL OF RIGHT FOR PATIENTS.

I ACKNOWLEDGE THAT INTEREST OR A FEE, AT THE PROVIDERS CURRENT RATE, MAY BE CHARGED on the balances owing to the provider that are past due. I ACKNOWLEDGE THAT ANY APPOINTMENTS NOT CANCELLED WITHING 24 HOURS ARE SUBJECT TO A $25.00 FEE.

Signature: ____ **Date:** ____________________

(Signature of insured or authorized person, patient or parent if minor)