WELCOME TO OUR OFFICE

PLEASE COMPLETE ALL SECTIONS OF THIS INFORMATION FORM

NAME: _____ DOB: _____ MRN: ___

Race: □ Asian □ Black/African American □ Caucasian □ American Indian □ Hispanic/Latino □ Other
Ethnicity: □ Hispanic/Latino □ Refuse □ Other

Local Address: _____

City/State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Northern Address: _____

City/State: _____ Zip: _____

Referring Physician: _____ Primary Care Physician: _____

Do we have permission to leave appointment information at the number(s) provided above: □ Y □ N

Person Responsible for Account (if different than above): Name: _____ Phone: _____

INSURANCE INFORMATION

Primary Insurance Company: _____ Policy #_____

Policy Holder Name: _____ DOB: _____

Secondary Insurance Company: _____ Policy #_____

Policy Holder Name: _____ DOB: _____

FEMALE PATIENTS: Is there a possibility that you may be pregnant? □ Y □ N

I have read all the information on this form and have completed the above information as true and correct. If necessary, I authorize RAVE to request office notes from my ordering physician and the release of any medical information needed for my medical care or other information as needed to process the claim.

HOW DID YOU HEAR ABOUT US (CHECK ALL THAT APPLY)?

□ Your doctor □ Friend □ Walk in □ Radio □ Newspaper □ Billboard □ Yellow pages

Please provide your e-mail address: _____

Patient or Guardian Signature: _____ Date: _____

Relationship (if other than patient): _____

NOTICE TO PATIENT

NAME: _____ DOB: _____ MRN: ___

RAVE is a diagnostic imaging center licensed by the State of Florida. Pursuant to the Patient Self-Referral Act of 1992, we are required to inform you if the physician who referred you to RAVE has a financial interest. Your referring physician does not have any financial interest in this facility.

All Patients: Do you request RAVE to submit this claim to your health insurance for today's visit? **□ Y □ N**

Are you a temporary or permanent resident of a skilled nursing facility? □ Y □ N

If yes, facility name: _____

Is this claim related to a Worker's Comp or Auto Accident? □ Y □ N Date of Accident or Injury_____

Please initial each paragraph:

_____ **RAVE is not responsible to know the terms of your individual policy. As a courtesy RAVE will file a claim with your primary and/or supplemental insurance company.**

_____ **I hereby acknowledge that I am responsible for any and all costs as outlined by my insurance company, including deductibles, co-insurances, and/or co-pays.**

_____ **I have reviewed my plan or checked with my insurance representative. It is my responsibility to know whether services at RAVE are covered under my policy.**

_____ **I hereby authorize, that in order for RAVE to service my account or to collect any amounts I may owe, the Lender/Creditor designated by RAVE may contact me by telephone at any telephone number associated with my accounts, including wireless telephone numbers, which might result in a charge to me. Methods of contact may include using pre-recorded/artificial voice messages.**

Medicare Patients Only:

_____ **RAVE agrees to accept assignment from Medicare. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release of any information necessary to process the claim and request payment of Medicare benefits on my behalf.**

The undersigned certifies that he/she has read the foregoing; and is the patient, or duly authorized as patient's guardian or general agent to execute the above and accept its terms.

_____ _____

Patient or Guardian Signature Relationship (if other than patient)

_____

Date