

RYE RADIOLOGY ASSOCIATES, LLP

DIAGNOSTIC RADIOLOGY and BREAST IMAGING CENTER

Account # _____

(To be completed by RRA)

Please provide us with the following information to enable us to maintain accurate records. Thank you.

Patient's Name: _____
Last First

Address: _____ Social Security Number: _____
_____ Birth Date: _____

Home Telephone Number: _____ Business Tel.Number: _____

Employer: _____

Address: _____

Please provide us with the name of your spouse or the name of your nearest relative 21 years of age or older.

Name: _____ Relationship: _____

Address: _____ Telephone Number: _____

Referring Physicians(s): Please list all physicians that should receive a copy of your medical report.

- 1) Name: _____ Address: _____
- 2) Name: _____ Address: _____
- 3) Name: _____ Address: _____

Please note payment is expected on the day of your exam regardless of insurance filing.

Medical Insurance: Medicare patients- We do accept assignment. We will however submit all Medicare Insurance claim forms.

Please enter your insurance information:

Insurance Company: _____ Policy Number: _____

Address: _____ Soc.Sec. # _____

Group Number: _____ Birthdate Policy.Holder: _____

Insurance Company: _____ Policy Number: _____

Address: _____ Soc.Sec. # _____

Group Number: _____ Birthdate Policy.Holder: _____

I authorize you to use and hereby consent to the release and disclosure, of all health and medical information pertaining to me (or if the patient is a minor, to my child _____), appropriate for diagnostic and therapy purposes, and for the processing and payment of all bills and claims for services rendered, including, where applicable, insurance claims, as well as any other lawful purpose.

Patient Signature

Date