PROGRESSIVE RADIOLOGY
Exceptional Service ◆ Every Time

Patient Information, Assignment of Benefits and Release of Information

Patient Name _____ MRN _____

Date of Birth _____ Email _____ Male ☐ Female ☐

Ethnicity: **(Circle One)** Caucasian/White African American/Black Hispanic/Latino Asian Middle Eastern Pacific Islander Native American/Alaskan Other

Address _____
Street *City, State, Zip*

Home Phone _____ Work Phone _____ Cell Phone _____

Emergency Contact _____ Phone _____ Relation _____

Primary Care Physician _____ Phone # _____

May we send you an e-mail to follow-up on the quality of service we provide today? Y / N

My signature and date below authorizes and acknowledges:

- Authorizes Progressive Radiology to direct bill Medicare, Medicaid, Medicaid Supplemental or any other insurance on my behalf.
- Authorizes the release of my medical information to my physician and to Medicare, Medicaid, Medicare Supplemental or other insurance and their agents and assigns.
- Authorizes and gives my permission to Progressive Radiology to obtain pertinent records from a hospital, medical facility or care provider who has been involved in my healthcare. Progressive Radiology may request medical records, for example prior imaging reports (CT, MRI, US, X-Ray) or surgical/pathology reports, which pertain to the reasons I am seeking care on this visit. This information will not be distributed beyond Progressive Radiology, and will be kept confidential.
- Authorizes Progressive Radiology to obtain medical or other information necessary in order to process my claim(s) including determining eligibility and seeking reimbursement.
- Acknowledges that I am financially responsible for any service not covered by my insurance as well as any co-payments, co-insurances and deductibles. I understand that if my account becomes delinquent, a rate of 1.5% will be applied monthly to the delinquent balance until the debt is paid in full.
- Acknowledges that should collection proceedings or other legal action become necessary, I understand that Progressive Radiology has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect my unpaid account. Further, I understand that in addition to my account balance, I am responsible for all attorney's fees, court costs, collection agency costs, and other assessments incurred to collect my unpaid account balance.
- Acknowledges that I have access to a copy of Progressive Radiology's **Notice of Privacy Practices** which is available in the reception area of the facility.
- I hereby attest that I have provided all insurance coverage applicable for services performed at this time. In the event that there is insurance coverage requiring pre-certification and it is not disclosed at the time of service, I will be held responsible for any outstanding balance due to lack of pre-certification.
- **FOR MINORS ONLY**: For Parents/Guardians of Minors: I, _____, the parent/legal guardian of _____ hereby give my consent for this test.
- Patients with a credit balance with Progressive Radiology of Illinois, LLC agree to apply credit balances to any open charges.
- Please take a moment to provide us with some important feedback. How did you find us? (Please check any boxes that apply)

☐	Your doctor referred you to us?	☐	Your doctor's staff referred you to us?
☐	Your insurance company gave you our information?	☐	You found us on line?
☐	A friend or family member referred you to us?	☐	You came to us because of our pricing?
☐	You are a previous patient?	☐	Other?

We do appreciate your choosing Progressive Radiology. We understand the importance of such a decision and want you to know that we are committed to providing you with accurate, precise results and exceptional care. Referring Physician: _____

_____ _____
Signature of Patient/Parent/Guardian *Date*

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