PROGRESSIVE RADIOLOGY
Exceptional Service ◆ Every Time

Patient Information, Assignment of Benefits and Release of Information

Patient Name _____ MRN _____

Date of Birth _____ SS# _____ - _____ - _____ 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 Email _____

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.
- **Maryland Health Information Exchange/CRISP:** We have chosen to participate in the Chesapeake Regional Information System for our Patients, Inc. (CRISP), a statewide internet-based health information exchange. As permitted by law, your health information will be shared with this exchange in order to provide faster access, better coordination of care and assist providers and public health officials in making more informed decisions. You may "opt-out" and prevent searching of your health information available through CRISP by calling 1-877-952-7477 or completing and submitting an Opt-Out form to CRISP by mail, fax or through their website at www.crisphealth.org

_____ _____

Signature of Patient/Parent/Guardian *Date*

Rev 3/5/12