PATIENT INFORMATION:	
Name:	Home Phone:
Date of Birth:	Cell Phone:
Gender:	SSN:
Address:	Email:
	Emergency Contact:
Have you been seen at St. Paul Radiology under a different name?	
PRIMARY INSURANCE:	SECONDARY INSURANCE:
Name:	Name:
Policy #:	Policy #:
Group #:	Group #:
Policy Holder:	Policy Holder:
REFERRING PROVIDER:	

Assignment of Benefits

I request payment of authorized benefits to be made directly on my behalf to St. Paul Radiology Outpatient Imaging for any services furnished to me by St. Paul Radiology Outpatient Imaging.

Guarantee and Agreement to Pay

I agree to be financially responsible for any charges not covered by my worker's compensation insurance, automobile insurance, personal injury carrier, Medicare or my health insurance plan (or, if signed by someone other than the patient, to guarantee payment for the care and treatment rendered to the patient named on this document). If I have no insurance I understand I am financially responsible for all charges incurred.

Patient, Legal Representative or Guarantor Signature Date Signed

Legal Representative Printed Name (if signing for patient)

I have received a copy of the Notice of Privacy Practices from St. Paul Radiology Outpatient Imaging.

Patient or Legal Representative Signature Date Signed

Legal Representative Printed Name (if signing for patient)