Reston Radiology Consultants

Patient Information Questionnaire

Patient's Legal Name (Last, First, MI)			**Date:**
Patient's Legal Address:	**City/State/Zip**		**Home Phone:**
E-Mail:		**DOB:**	**Sex:**
Social Security #:		**Marital Status:**	
Employer:		**Occupation:**	
Work Phone:	**Referring Physician:**		**Date of Onset:**
Symptoms:		**Have you had prior studies here?**	

Responsible Parties Information (*If different from patient)*

Responsible Party:		**Relationship**	**DOB:**
Social Security #:		**E-Mail:**	
Responsible Parties Address:	**City/State/Zip**		**Home Phone:**
Employer:			**Work Phone:**

Insurance Information

Primary Insurance Company:		**ID Number:**	**Group #:**
Insured:		**Employer:**	
Relationship to Patient:		**Treatment Authorization:**	
Secondary Insurance Company:		**ID Number:**	**Group #:**
Insured:		**Employer:**	
Relationship to Patient:		**Treatment Authorization:**	

Authorization and Assignment

I certify that all of the information I have reported on this form is correct and authorize the release of any necessary information, including medical information for this or any related claim, in order to determine benefits that I may be entitled to. I permit a copy of this authorization to be used in place of the original. By providing my email address, I understand I am consenting to receive communications from Reston Radiology Consultants.

I understand that the test my physician has referred me for may have multiple procedures associated to it, each with a unique procedure code. I acknowledge that these procedures will each be billed as separate line items, and may not be covered by insurance.

I hereby authorize payment directly to the physician for the benefits that are otherwise payable to me under the terms of my policy, but not to exceed my indebtedness to the physician for his services. In making this assignment to the physician, I understand and agree that any unpaid balance not covered by this policy will be billed to me.

I give permission to Reston Radiology Consultants to obtain any and all diagnostic reports and images from outside facilities relative to my exam today.

I acknowledge that I have received the Reston Radiology Consultants HIPAA Notice of Privacy Practices and Payment Policy. I give my permission for release of my medical information to the following individuals:

_____

_____ _____

Signature of Subscriber/Beneficiary **Date**