

*For Office Use Only*



WASHINGTON  
RADIOLOGY  
ASSOCIATES, P.C.



PI

**PATIENT INFORMATION**

Date \_\_\_\_\_

NAME Last	First	M.I.	Soc. Sec. Number	Date of Birth	Sex <input type="checkbox"/> M <input type="checkbox"/> F
ADDRESS Street	Apt. No.	City	State	Zip	
PHONE Home	Work / Extension	Cell	E-MAIL ADDRESS		
EMPLOYER OR SCHOOL NAME					
REFERRING PHYSICIAN NAME AND ADDRESS					
PRIMARY CARE PHYSICIAN NAME AND ADDRESS					
EMERGENCY CONTACT Name			Relationship		
Home Phone	Work	Cell			
IS THIS VISIT RELATED TO <input type="checkbox"/> Employment (Current or Previous) <input type="checkbox"/> Auto Accident If yes, State _____ <input type="checkbox"/> Other Accident Date of Accident _____					
<b>PARENT OR GUARDIAN (if minor)</b>					
NAME Last	First	M.I.	Soc. Sec. Number	Date of Birth	
ADDRESS Street	Apt. No.	City	State	Zip	
PHONE Home	Work	Cell	E-MAIL ADDRESS		
<b>PRIMARY INSURANCE INFORMATION</b>					
INSURANCE CO. NAME AND ADDRESS Street			City	State	Zip
POLICYHOLDER'S NAME			POLICYHOLDER'S SOC. SEC. NUMBER		
POLICY NUMBER	GROUP NUMBER		Date of Birth	Sex <input type="checkbox"/> M <input type="checkbox"/> F	
POLICYHOLDER'S PHONE Home	Work	Cell			
POLICYHOLDER'S EMPLOYER NAME AND ADDRESS					
<b>SECONDARY INSURANCE INFORMATION</b>					
INSURANCE CO. NAME AND ADDRESS Street			City	State	Zip
POLICYHOLDER'S NAME			POLICYHOLDER'S SOC. SEC. NUMBER		
POLICY NUMBER	GROUP NUMBER		Date of Birth	Sex <input type="checkbox"/> M <input type="checkbox"/> F	
POLICYHOLDER'S PHONE Home	Work	Cell			
POLICYHOLDER'S EMPLOYER NAME AND ADDRESS					

**Patient's Authorization**

I hereby authorize Washington Radiology Associates, P.C. to apply for healthcare benefits on my behalf for the services rendered. I request that the payments from any government-sponsored healthcare program, insurance company, or independent carrier with which WRA contractually participates be made directly to WRA. I certify that the insurance information I provided is correct.

I authorize the release of any necessary information, including protected health information for this or any other claim, to any government-sponsored healthcare program, insurance company, or independent carrier with which WRA contractually participates.

Other than insurance companies, government-sponsored healthcare programs, and treating physicians, I authorize release of my medical information to:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

I understand that I have the right to receive upon request, a copy of WRA's Notice of Privacy Practices which describes how WRA may disclose my protected health information (PHI).

Failure to provide requested information or to authorize release of PHI may result in nonpayment by insurance companies. I understand that all services rendered are the financial responsibility of the patient or guarantor and I may be held liable for WRA's fees due to non-payment by my insurance company.

I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me, in writing, at any time.

Signature of Patient

Parent or Guardian: \_\_\_\_\_ Date \_\_\_\_\_