The Sound Medical Building
1591 Boston Post Road • Guilford, Connecticut 06437
203-453-5123 • www.guilfordradiology.com

PATIENT INFORMATION REQUEST

Patient Name:____

If child, name of parent: ____________________________________

Patient date of birth:_____________________ Sex: ☐ Male ☐ Female

Patient Social Security Number:_______________

Home Address: ____
Street Address City ZIP code

____
Home Phone Work Phone Cell phone

Patient Employer: ____

Employer Address: ____
Street Address City ZIP code

Insured Name:____

Insured Date of Birth:_______________Social Security Number: _______________

Insured Employer: ____

Employer Address: ____
Street Address City ZIP code

INSURANCE INFORMATION

In order for us to provide service to you, you must present your insurance card and photo id during each visit.
I request that payment of authorized Medicare or other insurance benefits be made to Radiologic Associates of Middletown, PC on my behalf for services furnished to me. I authorize any holder of medical information about me the release to the Health Care Financing Administration and its agents, or my insurance company, any information needed to determine benefits payable for related services.

______________________________ ______________
Signature of patient or responsible party Date

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STATEMENT OF FINANCIAL RESPONSIBILITY

To our patients:

In some instances, our fee for service may not be covered in full by your insurance company.

Please understand that you are responsible for any balances due after your insurance company has made its payment. This balance may include co-payments, deductibles, non-covered services, and disallowed percentages not paid by your plan.

Your signature below indicates your understanding of your responsibility for any costs not paid by your insurance company. If you do not have health insurance, you will be required to pay the fees for our services at the time of your appointment. Our receptionist can provide you with a listing of the fees for the exam(s) for which you are scheduled and will review with you our discounts for uninsured patients.

I understand that I am financially responsible for all charges incurred, and I will pay the amount not covered by my insurance company.

____ _____________
Signature of patient or responsible party Date

AUTHORIZATION TO RELEASE PRIOR RADIOLOGICAL INFORMATION FOR COMPARISON PURPOSES

I authorize (prior radiological facility)____to release all relevant radiological information to Guilford Radiology for the purpose of comparison.

____ _____________
Signature of patient or responsible party Date