Diagnostic Imaging Consent and Insurance Billing Form

Please fill out this form prior to your imaging procedure. This document is formatted for printing and manual signature.

1. Patient Information

Full Name: _____

Date of Birth (MM/DD/YYYY): _____

Phone Number: _____

Residential Address: _____

2. Insurance Information

Insurance Company: _____

Policy ID / Member Number: _____

Group Number: _____

Policy Holder Name: _____

Relationship to Patient: _____

3. Referral & Procedure Information

Referring Physician Name: _____

Ordered Imaging Procedure (e.g., MRI, CT, X-Ray): _____

4. Consent and Financial Responsibility Statement

By signing below, I consent to the performance of the diagnostic imaging procedures ordered by my physician. I understand that I am financially responsible for all charges, whether or not paid by my insurance. I authorize the release of any medical information necessary to process this claim.

5. Patient Acknowledgement & Signatures

Printed Name of Patient or Legal Guardian: _____

Signature of Patient or Legal Guardian (Sign after printing): Sign on printed copy

Date (MM/DD/YYYY): _____