



**PATIENT INFORMATION**

Patient's Full Name \_\_\_\_\_ Social Security # \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Sex: M F Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Marital Status: M S D W

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone (\_\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_\_) \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone (\_\_\_\_\_) \_\_\_\_\_

Responsible party (if patient is a minor): \_\_\_\_\_

Social Security # \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Street Address (if different than patient): \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone (\_\_\_\_\_) \_\_\_\_\_ Relationship: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone (\_\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_\_) \_\_\_\_\_

Primary Insurance Plan Name: \_\_\_\_\_

Policy Holder's Name \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Policy Holder's Employer \_\_\_\_\_ Relationship \_\_\_\_\_

Secondary Insurance Plan Name: \_\_\_\_\_

Policy Holder's Name \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Policy Holder's Employer \_\_\_\_\_ Relationship \_\_\_\_\_

Each insurance company allows a certain amount to be paid for services provided. IAC is an approved medical provider for your insurance company and will file your insurance claim(s) for you. Providing quality medical care to our patients is our primary concern. Your insurance company will make payment directly to IAC except for the amount that is your responsibility. However, the ultimate responsibility for payment of this medical bill(s) lies with you.

Continued...

I understand and agree that regardless of insurance benefits available to the patient, I am fully responsible for any and all fees that are due to IAC for the procedure(s) and services provided to the patient, regardless of whether I am the individual receiving the services. If the insurance company does not pay or only partially pays IAC, I agree to be personally responsible for full payment. If it becomes necessary for IAC to utilize the services of a collection agency and/or an attorney to collect any past due amount for services rendered herein, I further agree to pay all costs of collection and attorney's fees. I also authorize IAC to release any information necessary to process my insurance claim. I authorize the release of any of my radiographic films/reports to IAC.

\_\_\_\_\_  
Signature of Guarantor

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**HIPAA Privacy Notice Acknowledgement:** The Privacy Notice for our practice is posted in our waiting room, which is required by law. In essence, this notice informs you that IAC will not sell or improperly handle your protected health information. We will only use this information to provide you with treatment, to conduct our routine health care operations and to obtain payment from you or your insurance company. Further, we will make every attempt to safeguard your protected health information from any outside intrusion. Please take this document home and read it so that you can understand your rights and responsibilities as a patient.

\_\_\_\_\_  
Patient's printed name

\_\_\_\_\_  
Signature of Patient

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_  
Witness

Date \_\_\_\_/\_\_\_\_/\_\_\_\_