

ULTRASOUND ASSOCIATES

Patient Demographic & Insurance Information

Patient Information

Name of Patient _____
First Middle Last

Birth Date _____ Social Security Number : _____
Mos Date Year

Responsible Party (if patient is a minor): _____ Gender **F M**
 Marital Status **S M O**

Street Address _____ Apt # _____

City _____ State _____ Zip _____

Home Phone () _____ Cell Phone () _____ Work Phone () _____

Email Address: _____ Referring Physician: _____

Primary Insurance Information

Name of Insured/Subscriber _____
First Middle Last

Patient's Relationship to Insured: Self Spouse Child Other

Birth Date _____ Social Security Number: _____
Mos Date Year

Employer: _____ Gender **F M**

Name of Insurance _____

Policy Number _____ Group Number: _____

Address of Insurance _____

City _____ State _____ Zip _____

In order to submit your claim, you must provide current medical insurance information. All insurances have time limitations on claim submission. It is your responsibility to provide current and accurate insurance information each visit. We will bill your insurance one (1) time. ***There will be an administrative fee of \$20.00 if we need to rebill your insurance.***

Secondary Insurance Information

Name of Insured/Subscriber _____
First Middle Last

Patient's Relationship to Insured: Self Spouse Child Other

Birth Date _____ Social Security Number: _____
Mos Date Year

Employer: _____ Gender **F M**

Name of Insurance _____

Policy Number _____ Group Number: _____

Address of Insurance _____

City _____ State _____ Zip _____

I request that payment of authorized Medicare and/or other Insurance Company benefits be made on my behalf to Ultrasound Associates for any services furnished to me. In making this assignment to Ultrasound Associates, I understand and agree that I will be responsible for any unpaid balance not covered. If it is determined that the services provided are not a covered benefit by Medicare and/or my health insurance plan, or payment for these services are denied, I agree to accept full financial responsibility. In the event the unpaid balance is turned over to a collections agency and/or attorney, I agree to pay all collection costs, attorney's fees and any other cost associated with the collection of any sum owed.

Signature

Date

Signature

Date

Signature

Date

Signature

Date

Signature

Date

Signature

Date

