

ADVANCED MOBILE DIAGNOSTICS, INC.
PATIENT INFORMATION SHEET

Please fill in the following information for our records. Please print clearly.

PATIENT NAME: _____ DATE OF SERVICE: _____

ADDRESS: _____ BIRTHDATE: _____

_____ PHONE # _____

REFERRING PHYSICIAN: _____ SOCIAL SECURITY # _____

PRIMARY INSURANCE: _____ MEDICARE # _____

INSURANCE ADDRESS: _____ IPA RECIPIENT # _____

_____ POLICY # _____

ADDITIONAL INSURANCE INFORMATION:

NAME OF COMPANY _____

ADDRESS: _____ POLICY # _____

NAME OF INSURED IF DIFFERENT THAN ABOVE: _____

RELATIONSHIP TO PATIENT: _____

I hereby authorize the release of any medical information necessary for the processing of insurance, Medicare assigned cases and/or quality assurance. I hereby assign all medical benefits to include major medical benefits to which I am entitled to Advanced Mobile Diagnostics, Inc. I acknowledge that I am responsible for all deductibles, co-pay and non-covered services. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

Patient Signature: _____ Date: _____

Signature on File

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Patient Signature: _____ Date: _____

FOR OFFICE USE ONLY

Test(s) Performed: _____ ICD9 Code(s): _____

_____ ICD9 Code(s): _____

Place of Service: _____ Tech: _____

Provider: Advanced Mobile Diagnostics, Inc., P. O. Box 3733, Peoria, IL 61612-3733

Is patient Part A with SNF responsible: Yes No