500 Landmark Ave., Bloomington, IN 47403
(812)333-7676

PATIENT INFORMATION

PLEASE USE LEGAL NAME

First Name_____Initial_____Last Name_____

Address_____

City_____State_____Zip Code_____

Phone(Home)_____(Work)_____

Date of Birth_____Age_____Sex_____Social Security #_____

Employer_____Referring Doctor_____

If Patient is a Minor, Please Complete:

Parent/Guardian Name_____

Address (If different than above)_____

Are you a nursing home resident?_____(If yes, where?)_____

ASSIGNMENT OF INSURANCE BENEFITS:
I hereby authorize and direct that payment of any insurance benefits otherwise payable to me should be paid directly to the physicians with SIRA Imaging Center, LLC ("SIRA"). This assignment shall be effective until such time as I provide a written revocation to my health insurance plan (with a copy to SIRA) of this assignment. Payment is not to exceed the charges stated in any invoice, claim, or statement provided by SIRA. By executing this assignment, I acknowledge and agree that I am financially responsible to SIRA for charges covered by this assignment regardless of the status of any claims filed or payment decisions by my insurance carrier(s).

AGREEMENT REGARDING NON-COVERED SERVICES:
I understand that I will be receiving certain medical and health care service(s) from SIRA Imaging Center, LLC that may not be covered in full or in part by my health insurance plan. If my health insurance plan determines that the service(s) I receive are not covered under my plan, or are not fully covered under my plan, I agree to be responsible to SIRA for payment of the full amount outstanding for such service(s). I acknowledge and agree that I will be charged and billed by SIRA at their customary rate.

As a courtesy, SIRA will file insurance claims on my behalf. I understand that it is my responsibility to provide current insurance information for billing purposes as well as be aware of any network affiliation or preauthorization that is required by my health insurance plan.

Signing below indicates you have read and understand the above listed conditions:

_____ _____

(Patient, Parent, Legal Representative, or Guardian) **(Date)**