Diagnostic Imaging Associates

100 College Parkway Suite 180 Williamsville, NY 14221

Patient Information

_____ _____ _____
Last Name **First Name** **Middle Initial**

_____ _____
Street Address **Apt # or P.O. Box#**

_____ _____ _____ (____) _____ - _____
City **State** **Zip Code** **Telephone Number**

_____ ___/___/_____ _____ _____
Social Security Number **Date of Birth** **M / F** **Previous Patient Y / N**

_____ _____
Referring Physician **Copy to additional Physician**

Guarantor (Insurance Policy Holder)

_____ _____ _____
Relationship to Patient **Last Name** **First Name**

_____ _____
Street Address **Apt # or P.O. Box#**

_____ _____ _____ (____) _____ - _____
City **State** **Zip Code** **Telephone Number**

_____
Employer

Film sign out Policy

Diagnostic Imaging Associates has installed a computerized radiology system, which allows us to view digital images on monitors in place of film. Patients interested in receiving films or a CD should notify the technologist at the time of the exam. All films or CD's being requested after the exam will require a 24 hours notice. All persons picking up films or CD's must show a photo I.D. and tell us to which physician the films or CD's will be going.

PLEASE NOTE: For all insurance companies with whom Diagnostic Imaging Associates is **NOT** a participating provider, for providers that deem your exam **NOT MEDICALLY NECESSARY**, or if a preauthorization and/or a referral is required and is not obtained, or incorrect: The guarantor is ultimately responsible for full payment of account, including outside collection costs.

I understand I am responsible for all patient charges and hereby authorize release of information regarding the services rendered for payment of insurance benefits to be paid directly to Diagnostic Imaging Associates.

Signature of responsible party _____ Date _____