Date of Service:	Appt. Time:	Pt. ID.	Acct#:
Procedure Ordered:			
Referring Physician:	Ref. Phy. Phone:	Ref. Phy. Fax:	
Ref. Phy. Address:	City	ST	Zip
Last Name	First	MI	Gender
SSN	DOB	Marital	

Address 1			**CONTACT**
Address 2			Day Phone
City	State	Zip	Evening Phone
RESPONSIBLE PARTY			Other
Last Name	First	MI	E-mail
SSN	DOB	Relationship	**EMERGENCY**
Address			Name
City	State	Zip	Relationship
Phone	Employer		Phone

BILLING INFORMATION SELF PAY ☐ INSURANCE ☐ DIRECT BILL ☐

Payer Name		Plan Name	
Address			
City	State	Zip	Phone
Subscriber Relationship	Last	First	MI
DOB	Policy#	Group#	

Financial Responsibility: By accepting any medical service or treatment, including but not limited to the above listed procedure(s), the undersigned patient/responsible party agrees to pay Capitol Imaging Services, all charges for such service or treatment. Your insurance is filed as a courtesy to you. All co-pays, deductibles, co-insurance, previous balances, and fees for non-covered services are due at the time of your visit. We will be happy to provide you with a statement of your account, when requested, to file with a secondary or tertiary insurance, once your account is paid in full. We will file secondary insurances, when needed, if required by a specific contract. If you are a Medicare recipient, we will file your Medicare as required for participation in the Medicare program.
We will provide the best possible care for you. Services we provide to you may or may not be covered by your insurance due to routine, non-covered, or "deemed medically unnecessary" by your insurance company. In the event your insurance company does not cover your services, you will be responsible. We will make every effort to let you know if we feel your insurance company may not cover your services. You are responsible for knowing the benefits/coverage of your insurance.

Signature:_______________________________________

I agree that the above information is true and accurate. By checking the box, I have been made aware of my privacy rights. ☐

Are you currently involved in a clinical trial study? Yes___________ No___________

_______________________________ _______________________________
Signature Date