2110 Airway Avenue, Kingman, AZ 86409 **(928) 681-1800**

ALL INSURED PATIENTS: It is our policy to bill (as a courtesy) insurance carriers; however, it is the patient's responsibility to know whether or not your particular insurance will pay Mountain West Medical Imaging. If your insurance company fails to pay your account within a timely manner, payment in full will be due from the patient or responsible party. **It is your responsibility to check with your individual insurance company regarding payment. Any balance not paid by your insurance company is your responsibility.**

We will make every effort to complete insurance forms for all your procedures performed at Mountain West Medical Imaging. However, the financial responsibility for services rendered rests with the patient or responsibility party if your insurance company refuses to pay. **Therefore, it is very important that if you have a change of insurance, address, or phone number that you notify our office immediately.** If you fail to notify our office of any change, your account balance will be your responsibility and any unpaid account will be sent to collections. This will include any collection costs.

MEDICARE PATIENTS: We accept assignment for Medicare insurance. This means we agree to accept the "allowable charge" as determined by Medicare as full payment. The patient must remember that Medicare generally pays 80% of the "allowable charge" and the patient is responsible for the remaining 20% plus the annual Part B deductible.

CASH/SELF-PAY: I understand it is customary that exams be paid for at the time of service. Payment in full is expected at each examination.

There will be a $15.00 charge on all returned checks.

I hereby authorize my insurance company to send payment to Mountain West Medical Imaging. I authorize Mountain West Medical Imaging to release any information during the course of my examination to my insurance company, or any other provider treating me.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received a copy of Mountain West Medical Imaging's **Notice of Privacy Practices.** I understand that Mountain West Medical Imaging will offer any updates to the **Notice of Privacy Practices** should it be amended, altered, or changed in any way.

Films will only be provided once at your doctor's request. (Should another set of films for the same exam be requested, there will be a $7.00 per sheet charge.) Films for your personal records will cost $7.00 per sheet to be paid in advance OR a CD will be provided at no charge with 24 hour advance notice.

Patient's Name (PRINT) ____

Patient's Signature ____ Date ___/____/____

□ Patient refused to sign □ Patient unable to sign because ____________________________

WELCOME TO MOUNTAIN WEST MEDICAL IMAGING

PATIENT INFORMATION

Today's Date: ______________________________

Patient Last Name: _________________________ Patient First Name:_________________________________

Mailing Address: ____________________________________ City: _______________ State:______ Zip: ______

Are you a winter visitor? □ Yes □ No Local Address: ____

Home Phone: _______________________ Work Phone: _____________________ Cell:__________________

Birthdate: _____- _____ - _____ Sex: □ Female □ Male Marital Status: □ Single □ Married □ Widowed

Social Security #: __________- _________ - _________ Employer: _______________________________________

Employed: □ Yes □ No □ Disabled □ Retired Patient's Nickname: _________________________________

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PRIMARY INSURANCE INFORMATION

Insurance Company Name: ____

Subscriber Name: ________________________________ Employer:____________________________________

Insurance/Policy ID: _________________________________ Group No: _________________________________

Relationship to Patient: _________________________ Subscriber Social Security: ______________________

Subscriber Date of Birth: ______________________________

SECONDARY INSURANCE INFORMATION

Insurance Company Name: ____

Subscriber Name: ________________________________ Employer:____________________________________

Insurance/Policy ID: _________________________________ Group No: _________________________________

Relationship to Patient: _________________________ Subscriber Social Security: ______________________

Subscriber Date of Birth: ______________________________

I give permission for _______________________________ relationship _________________________to pick up my my medical records.

EMERGENCY CONTACTS

Name: _____________________________________ Phone: ____

Relationship to Patient: ___________________________

Name: _____________________________________ Phone: ____

Relationship to Patient: ___________________________

(PLEASE COMPLETE BACK SIDE)