NEW ADDRESS FORM

Please update any changes since your last visit.

Patient Name ______________________ **DOB** ____________ ☐ **FEMALE** ☐ **MALE**

Address ______________________ **Phone Number** ____________

Insurance Co. ______________ **Policy #** ____________ **Group #** ____________

Insurance Address ______________________

____________ ______________________ ____________

Relation to patient **Name of Insured (if not the patient)** **DOB**

Assignment of Insurance Benefits: Patients with insurance please read and sign: I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, private insurance, and any other health plans to: **North Star Radiology.** This assignment will remain in effect until revoked by me in writing; a photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges that are not paid by said insurance; I hereby authorize said assignee to release all information necessary to secure payment.

Consent for Treatment: I hereby authorize **North Star Radiology** to provide me with diagnostic imaging services as requested by my health care provider. I have read, understood and agreed to the above financial policy for payment of professional fees. I understand that the patient is ultimately responsible for all professional fees.

______________________________________ ____________

X Signature of patient **Date**

EC