PATIENT REGISTRATION
INFORMATION UPDATE

NorthStar RADIOLOGY

PATIENT INFORMATION

Last Name: _____ **First Name**: _____ **Middle Initial(s)**: _____

Date of Birth: _____/_____/_____ **Gender**: ☐ Male ☐ Female

Billing Address (Street / P.O. Box): _____

City: _____ **State**: _____ **Zip Code**: _____

INSURANCE INFORMATION

Insurance Company: _____

Insurance Group Number: _____ **Insurance Policy Number**: _____

Patient Relation to Insurer: ☐ Self ☐ Spouse ☐ Parent ☐ Child ☐ In-Law ☐ Friend ☐ Significant Other

Insured Last Name: _____ **Insured First Name**: _____ **Middle Initial(s)**: _____

***IF INSURANCE CARRIER'S INFORMATION IS THE SAME AS THE ABOVE PATIENT INFORMATION, PLEASE WRITE "SAME AS ABOVE"**: _____

***Insured Billing Address (Street / P.O. Box)**: _____

***City**: _____ ***State**: _____ ***Zip Code**: _____

***Insured Employer**: _____ ***Work Phone Number**: (_____) _____ - _____ ext. _____

ASSIGNMENT OF INSURANCE BENEFITS – PLEASE COMPLETE WITH RECEPTIONIST AT CHECK-IN ON DATE OF YOUR EXAM

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.

Patient Signature: _____ **Date**: _____ / _____ / _____

NORTH STAR RADIOLOGY
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