RIVER CITY IMAGING CENTERS
RCIC

LAST NAME	FIRST NAME	MIDDLE INITIAL

MAILING ADDRESS	APT #	CITY	STATE	ZIP CODE

HOME PHONE #	CELL PHONE #	WORK PHONE #	DATE OF BIRTH	SEX ☐ M ☐ F	SS#

EMAIL	REFERRING PHYSICIAN	EXPLAIN CURRENT SYMPTOM(S) FOR THIS EXAM(S)

INSURANCE INFORMATION- A COPY OF YOUR INSURANCE CARD AND/OR PAYMENT WILL BE REQUIRED

1. PRIMARY INSURANCE	POLICY HOLDER	SS#	POLICY HOLDER EMPLOYER:
☐SELF ☐SPOUSE ☐MOTHER ☐FATHER ☐OTHER	BILLING ADDRESS		
	POLICY ID #	GROUP/ PLAN #	

MEDICARE PATIENT ONLY: Are you currently participating in a Clinical Research Trial? ☐YES ☐NO

2. SECONDARY INSURANCE	POLICY HOLDER	SS#	POLICY HOLDER EMPLOYER:
☐SELF ☐SPOUSE ☐MOTHER ☐FATHER ☐OTHER	BILLING ADDRESS		
	POLICY ID #	GROUP/ PLAN #	

3. WORKERS' COMPENSATION

EMPLOYER	EMPLOYER ADDRESS	WORK PHONE #

W/C INSURANCE CARRIER	W/C INSURANCE CARRIER ADDRESS	CLAIM #

DATE OF INJURY	ADJUSTER'S NAME	ADJUSTER'S PHONE #

INSURANCE ASSIGNMENT
I hereby consent to the release of information to my insurance carrier regarding my treatment at River City Imaging Centers (RCIC). I further authorize payment to be made directly to RCIC for any insurance benefits to which I am entitled.

STATEMENT OF FINANCIAL RESPONSIBILITY
I understand and agree that I am financially responsible for any and all charges for services rendered by RCIC regardless of the existence of a health plan or health insurance and assignment of insurance benefits. Many insurance companies have additional stipulations that may affect coverage. I understand I am responsible for any amounts not covered by my insurer, unless RCIC had agreed by contract with my insurer to accept such lesser amounts. If my insurance carrier denies any part of my claim, I will be responsible for the balance. RCIC bills secondary insurance only as a courtesy. Any balance not paid by secondary insurance will become my responsibility to pay.

RELEASE OF RCIC MEDICAL RECORDS TO HEALTH CARE PROVIDERS
I hereby consent and authorize RCIC to release any and all information in my medical records to my physician(s) and other health care providers involves in providing care to me.

RELEASE OF MEDICAL RECORDS TO RCIC
I hereby request and authorize my health care provider(s) to release to RCIC medical records, x-ray films, reports and pathology results as needed in assisting RCIC in providing my medical consultation, care and/or treatment.

OUT OF NETWORK INSURANCE- ACKNOWLEDGEMENT OF POTENTIAL LIABILITY (initial if applicable)
I am aware that the RCIC facility where I am having services performed is not considered to be "In Network" with the third-party insurance plan that provides my payment coverage. I acknowledge that the insurance plan may, therefore, provide benefits at the "Out of Network" level. I understand that I am personally responsible for paying any remaining balance due for these services. _____Initials

X_____ _____
Signature of Patient/Legally Authorized Person /Financially Responsible Party Date

_____ _____
PLEASE PRINT NAME SS# (IF OTHER THAN PATIENT)