

PATIENT INFORMATION

LAST NAME _____ FIRST NAME _____ MIDDLE _____

STREET ADDRESS _____ CITY _____

STATE _____ ZIP CODE _____ TEL#(____)-____-_____

DATE OF BIRTH ____/____/____ SOCIAL SECURITY# _____-____-_____

SINGLE _____ MARRIED _____ OTHER _____

EMPLOYER _____

STREET ADDRESS _____ CITY _____

STATE _____ ZIP CODE _____ TEL# (____)-____-_____

EMERGENCY CONTACT _____

RELATIONSHIP _____ TEL#(____)-____-_____

I authorize the release of any medical information necessary to process the health insurance claim form. I authorize payment of medical benefits to Vermont Radiologists or supplier for service(s) described on the health insurance form. I take responsibility for fees owed if the insurance carrier does not respond within 30 days or if a balance remains. In the event that it becomes necessary for Vermont Radiologist to refer your account to our collection agency, incur collection cost or institute a suit to collect any amount due and payable, you (the patient) agrees to pay such additional collection costs, charges and expenses. Including attorney's fee if the account is placed in the hands of an attorney or an agency for collection.

Signature _____ Date _____

**Acknowledge Receipt of Vermont Radiologists
Notice of Privacy Practices**

Signature _____ Date _____

