Diagnostic Imaging Services of Idaho
ULTRASOUND ~ NUCLEAR MEDICINE
1951 Bench Road. – Suite F – Pocatello, ID 83201 – Phone (208) 237-0977 – Fax (208) 237-0985

Patient Information

Name _____ **Ordering Physician** _____ **Date** _____
Last First Initial

Address _____ **City, State, Zip** _____

Home Phone _____ **Cell Phone** _____

Social Security Number _____ **Sex** ◯ Male ◯ Female **Date of Birth** _____ **Age** _____

EMPLOYER _____ **Work Phone #** _____

Marital Status ◯ Married ◯ Single ◯ Widow ◯ Divorced

Ethnicity ◯ Hispanic or Latino ◯ Not Hispanic or Latino ◯ Hawaiian or other Pacific Island ◯ Other

Have you Been to Our Office Before? ◯ Yes ◯ No

If Yes, has your insurance changed? ◯ Yes ◯ No **If Yes, please fill out the insurance Information below**

☐ **Check here if patient is not a minor and responsible party is same as above**

Responsible Party Name _____ **Date of Birth** _____

Address _____ **City, State, Zip** _____

Social Security Number _____ **Home Phone** _____ **Cell Phone** _____

Insurance Information

Primary Insurance _____ **Policy Holder's Name** _____

Date of Birth _____ **Sex** ◯ Male ◯ Female **Social Security Number** _____

Group Number _____ **Policy Number** _____

Insurance Address _____
Patients that Have Medicare, Medicaid, Blue Cross or Blue Shield DO NOT need to fill in the address

Secondary Insurance _____ **Policy Holder's Name** _____

Date of Birth _____ **Sex** ◯ Male ◯ Female **Social Security Number** _____

Group Number _____ **Policy Number** _____

Insurance Address _____
Patients that Have Medicare, Medicaid, Blue Cross or Blue Shield DO NOT need to fill in the address

Assignment and Release:

◯ **NON MEDICARE:** I hereby assign my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any non-covered services. I authorize the physician to release any information required to process this claim.

◯ **MEDICARE:** I request that payment of authorized Medicare benefits be made wither to me or on my behalf to Diagnostic Imaging Services of Idaho for any services furnished to me by that practice. I authorize and holder of medical information about me to release to the Centers for Medicare and Medicaid Services, formally the Health Care Financing Administration and its agents any information to determine these benefits or the benefits payable for related services.

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

Relationship to Patient if Signing for a minor: _____

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ACKNOWLEDGMENT NOTICE OF PRICACY PRACTICES

I, _____, acknowledge and agree that I have received and/ or read a copy of
Patient Name
Diagnostic Imaging Services of Idaho's Notice of Privacy Practices.

I am aware of and understand the HIPAA Privacy Act.

Patient's Name: _____

Patients Date of Birth: _____ / _____ / _____

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

Relationship to Patient if Signing for a minor: _____

ACKNOWLEDGMENT OF INTEREST RATE CHARGES ON PAST DUE ACCOUNTS

Diagnostic Imaging Services of Idaho charges all patients an interest rate of 5.00% APR on past due amounts over 90 days. If your insurance has a deductible that hasn't been met this will apply to you. Interest will begin to accrue 90 days after the date of service. If you have any questions about this policy or would like to set up a payment plan, call us at (208) 237-0977. Please sign below acknowledging that you have read and accept the interest rate terms as explained above.

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

Relationship to Patient if Signing for a minor: _____

We appreciate being able to serve you!