LONGHORN IMAGING CENTER

Patient's Name_____ _____ _____ **Sex**: M / F
Last *First* *M.I.*

Date of Birth _____/_____/_____ **Home/Cell #** _____**Work #** _____

Home Address _____ **Apt#**_____

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

E-mail Address:_____

How did you hear about us? Doctor Insurance Co. Friend/Family_____
(circle one) **If a Friend/Family Member referred you, please tell us the person's name so we can thank them!**

Primary Insurance Information

Policyholder Name _____ Date of Birth_____/_____/_____

Relationship to Policyholder: Self_____ Spouse _____Child_____ Other_____

Secondary Insurance Information

Policyholder Name _____ Date of Birth_____/_____/_____

Relationship to Policyholder: Self_____ Spouse _____ Child_____ Other_____

Work Comp and PIP Insurance Information

Employer Name:_____SSN #: _____

Address:_____ City: _____ State:_____ Zip_____
Date of Injury: ____/____/____ State where injury occurred:_____

Injury is: Work Related _____ Car Accident_____ Other (describe)_____

Responsible party name _____ _____ _____
if patient is minor *Last* *First* *M.I*

HIPAA Acknowledgment

I herby acknowledge that I have been made aware that Longhorn Imaging has a Privacy Policy in place accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). As a patient I acknowledge the following: Longhorn Imaging has a privacy policy in effect and has made this policy available for review by placing a framed version of the policy in the waiting room. I am entitled to a copy of the Privacy Policy if I desire a copy for my personal file.

Upon your review of the above please sign at the bottom acknowledging that you have been advised of the privacy policy implemented by Longhorn Imaging and have read and understand the form. If you desire a copy of the Privacy Policy please request one at this time.

☐ No, I do not wish to obtain a copy of the policy but I am aware one exists.

☐ Yes, I do want a copy of the HIPAA Privacy Policy. Policy was given to patient on
_____ by _____.
Date LIC Representative

I authorize the release of any previous results or images in the event LIC is in need of them to help with the diagnosis of my procedure today. I permit a copy of this authorization to be used in place of the original. I understand and acknowledge that I am personally responsible for the services rendered at this facility. Longhorn Imaging, Inc. will bill my insurance carrier as a courtesy. In the event of non-payment, I understand I will be responsible for any outstanding balances.

X _____ _____
Patient signature or guardian for the minor patient *Date*