

MARIETTA DIAGNOSTIC CENTERS, LLC

Marietta Imaging at North Cobb

4791 South Main Street Suite 140

Acworth, GA 30101

678 701-6868

Marietta Imaging Center

780 Canton Road Suite 230

Marietta, GA 30060

770 792-1234

East Cobb Open MRI

1197 Johnson Ferry Road Suite 200

Marietta, GA 30068

770 971-7284

FIRST MI LAST HOME# WORK#
STREET ADDRESS APT. # CITY STATE ZIP
SSN # - - DOB: / / AGE: SEX: M F MARITAL STATUS: M S D W

PATIENT'S EMPLOYER:
EMPLOYER'S ADDRESS:
IN CASE OF EMERGENCY, CONTACT NAME:
RELATIONSHIP: CONTACT NUMBER:

PRIMARY INSURANCE PLAN NAME:
POLICY HOLDER'S NAME:
POLICY HOLDER'S SOCIAL SECURITY #: BIRTHDATE:
POLICY HOLDER'S EMPLOYER:

SECONDARY INSURANCE PLAN NAME:
POLICY HOLDER'S NAME:
POLICY HOLDER'S SOCIAL SECURITY #: BIRTHDATE:
POLICY HOLDER'S EMPLOYER:

EACH INSURANCE COMPANY ALLOWS A CERTAIN AMOUNT TO BE PAID FOR SERVICES PROVIDED. MARIETTA DIAGNOSTIC CENTERS ARE APPROVED MEDICAL PROVIDERS FOR YOUR INSURANCE COMPANY AND WILL FILE YOUR INSURANCE CLAIM(S) FOR YOU. YOUR INSURANCE COMPANY WILL MAKE PAYMENT DIRECTLY TO MARIETTA DIAGNOSTIC CENTERS EXCEPT FOR THE AMOUNT THAT FALLS UNDER YOUR RESPONSIBILITY.

I AUTHORIZE MARIETTA DIAGNOSTIC CENTERS THE RELEASE OF MY RADIOGRAPHIC FILMS/REPORTS AND ANY INFORMATION NECESSARY TO PROCESS MY INSURANCE CLAIM. I HEREBY AUTHORIZE MARIETTA DIAGNOSTIC CENTERS TO RELEASE ANY OR ALL INFORMATION CONTAINED IN MY FILE TO THE ABOVE-DESIGNATED WORKER'S COMPENSATION CARRIER OR THIRD PARTY PAYOR FOR THE SOLE PURPOSE OF RECEIVING PAYMENT FOR SERVICES RENDERED. I UNDERSTAND AND AGREE THAT REGARDLESS OF INSURANCE BENEFITS AVAILABLE TO THE PATIENT, I AM FULLY RESPONSIBLE FOR ANY AND ALL FEES THAT ARE DUE MARIETTA DIAGNOSTIC CENTERS FOR THE PROCEDURE(S) AND SERVICES PROVIDED TO THE PATIENT, REGARDLESS OF WHETHER I AM THE INDIVIDUAL RECEIVING THE SERVICES. IF THE INSURANCE COMPANY OR THIRD PARTY PAYOR DOES NOT PAY OR ONLY PARTIALLY PAYS MARIETTA DIAGNOSTIC CENTERS, I AGREE TO BE PERSONALLY RESPONSIBLE FOR FULL PAYMENT. IF IT BECOMES NECESSARY FOR MARIETTA DIAGNOSTIC CENTERS TO UTILIZE THE SERVICES OF A COLLECTION AGENCY AND/OR AN ATTORNEY TO COLLECT ANY PAST DUE AMOUNTS FOR SERVICES RENDERED HEREIN, I FURTHER AGREE TO PAY ALL COSTS OF THE ATTORNEY'S FEES AND COLLECTION AGENCY. "I understand that any monies collected at the point of service is only an estimate of what will be owed after insurance has adjudicated that claim and that the balance due will be billed to the patient after final insurance adjudication. "

X DATE:
SIGNATURE OF GUARANTOR

PRIVACY NOTICE ACKNOWLEDGEMENT: ATTACHED IS THE PRIVACY NOTICE FOR OUR PRACTICE WHICH IS REQUIRED BY LAW. THIS NOTICE INFORMS YOU THAT MARIETTA DIAGNOSTIC CENTERS WILL NOT SELL OR IMPROPERLY HANDLE YOUR PROTECTED HEALTH INFORMATION. WE WILL ONLY USE THIS INFORMATION TO PROVIDE YOU WITH TREATMENT, TO CONDUCT OUR ROUTINE HEALTH CARE OPERATIONS AND TO OBTAIN PAYMENT FROM YOU OR YOUR INSURANCE COMPANY. WE WILL MAKE EVERY ATTEMPT TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION FROM ANY OUTSIDE INTRUSION.

X DATE:
PATIENT SIGNATURE:
MDC WITNESS: DATE: