PET/CT IMAGING OF SAN JOSE

2211 Moorpark Avenue, Suite 220 San Jose, CA 95128
Ph. 408-297-8844, Fax 408-297-8220

Last Name:_____First Name_____Sex:___Age:___

Street Address:_____City:_____State:____Zip:_____

Home Phone#:_____Work Phone#:_____Cell Phone#:_____

Mailing Address (If Different):_____

Date Of Birth:_____Social Security#:_____Patient Employed By:_____

Employer Business Address_____Employer Business Phone#:_____

Referring Physician:_____Primary Care Physician:_____

Marital Status: Married_____Single_____Widowed_____Divorced_____

Responsible Party If Minor:_____

In Case Of Emergency, Who Should Be Notified? _____Relationship:_____Phone#:_____

ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION:
I assign directly to PET/CT and Nuclear Medicine Imaging of San Jose all medical benefits, if any, otherwise payable to me for services rendered. I herby authorize PET/CT Nuclear Medicine Imaging of San Jose to release all information necessary to secure the payment of benefits. I authorize the use of this on all my insurance submissions.
I herby authorize the release of all medical information requested by my attending physician(s) and any other medical agencies involved in my care.

PATIENT RESPONSIBLITY AGREEMENT:
By signing below, I agree to pay Provider for those Services determined for the reason(s) specified below not to be covered under my Benefit Agreement: Not medically necessary; primarily for comfort and convenience; or Otherwise not a covered benefit or excluded under my coverage. I understand that a provider may not charge me for a service determined to be not medically necessary unless I specifically agree to pay for it. I also understand that the Provider and/or I may appeal any determination that a service is not medically necessary by filing a grievance or appeal with my insurance or the Department of Managed Health Care ("DMHC") pursuant to the grievance and appeals procedures described in my Benefit Agreement or Evidence of Coverage ("EOC"). I also understand that I may also have the right to Independent Medical Review through the DMHC, as described in my Benefit Agreement or EOC. For the services listed; radiopharmaceuticals, administration charges, PET, CT and/or Nuclear Imaging, I understand that I am financially responsible for the amount billed to my insurance. I understand that all fees are subject to change based on actual exams performed. I understand that in the event legal action should become necessary to collect an unpaid balance due for medical services rendered, I agree to pay for reasonable attorney fees or other such costs as the court determines proper.

HIPPA NOTICE OF PRIVACY PRACTICES:
We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objection to this for, please ask to speak with our HIPPA Compliances Officer in person or by phone at our main phone number.

The signature below is an acknowledgement and an acceptance that you have received the Notice of our Privacy Practices, Assignment of Benefits, Release of Information and Patient Responsibility Agreement.

Signature of Patient: _____ Date: _____