ROSETTA RADIOLOGY
1421 THIRD AVENUE, (bet. 80th & 81st Street)
NEW YORK, N.Y. 10028

APPOINTMENT TIME PROCEDURE NP / OP

PLEASE PRINT DATE _____

PATIENT NAME _____

STREET ADDRESS _____APT# _____DATE OF BIRTH _____

CITY, STATE, ZIP _____ HOME # _____
WORK #_____
CELL # _____

POLICY HOLDER IF OTHER THAN PATIENT: _____

RELATIONSHIP TO PATIENT: _____

STREET ADDRESS _____APT# _____DATE OF BIRTH _____

CITY, STATE, ZIP _____ HOME PHONE _____

INSURANCE PLAN: _____

ID# _____

REFERRING DRS NAME & ADDRESS: _____

_____

OTHER TO RECEIVE REPORTS: DR. _____
STREET ADDRESS _____
CITY, STATE, ZIP _____
DR. _____
STREET ADDRESS _____
CITY, STATE, ZIP _____

I authorize the release of any medical or other information necessary to process this claim. I agree to pay for all medical services rendered, including all bills not covered by my insurance. I authorize payment of medical benefits to the undersigned physician.

As required by HPAA, we will use your medial records only for treatment, payment and healthcare operations.

Signed _____ Date _____

PLEASE TAKE THIS FORM TO THE BOOKKEEPER BEFORE LEAVING