avestēe
WOMEN'S IMAGING CENTER
OF ALAMO HEIGHTS

PATIENT INFORMATION
PLEASE FILL OUT COMPLETELY

PATIENT NAME: _____

DOB: _____ SSN:_____-_____-_____

EMAIL (For appointment reminders): _____

ADDRESS: _____

_____

CONTACT PHONE# _____ ALTERNATE# _____

PRIMARY INSURANCE:_____

IS PRIMARY SELF OR SPOUSE: _____

IF SPOUSE: NAME: _____

DOB:_____ SSN:_____-_____-_____

PHYSICIAN(S) :_____

REASON FOR VISIT TODAY:_____

PREVIOUS MAMMOGRAM? YES NO

IF YES, DATE:_____/_____/_____ LOCATION:_____

STATEMENT OF FINANCIAL RESPONSIBILITY :
I understand and agree that, except as may be specifically limited to my health plan or health insurance, I am financially responsible for any and all charges for services rendered by Avestee Women's Imaging Center **(AWIC)** regardless of the existence of a health plan or health insurance and assignment of insurance benefits.

INSURANCE ASSIGNMENT:
I hereby consent to the release of information to my insurance carrier regarding my treatment at AWIC. I further authorize payments to be made directly to AWIC for any insurance benefits to which I am entitled.

CONSENT OF MEDICAL RECORDS AND INFORMATION:
I hereby consent and authorize AWIC to release any and all information in my medical records to my physician(s] and other health care providers involved in providing care to me. I hereby request and authorize health care provider(s) to release to AWIC: medical records, x-ray film/CD's, reports and pathology results as needed to assisting AWIC in providing my medical consultation, care and/or treatment.

x _____ DATE: _____
SIGN Patient/Legally Authorized Person/Financially Responsible Party

AVESTEE WOMEN'S IMAGING CENTER OF ALAMO HEIGHTS
303 W SUNSET RD STE 200 SAN ANTONIO TX 78209
210 826·2666 FAX 210 314·7545