avestēe WOMEN'S IMAGING CENTERS | SOLIS Mammography

Emp. Int._____

PATIENT INFORMATION
PLEASE FILL OUT COMPLETELY

Patient Name: _____DOB: _____

SSN: _____-_____-_____ Email: _____

Primary Phone #_____ (C)(H) Alternate #_____(C)(H)

Address: _____City _____State _____Zip_____

Primary Insurance: _____

Primary Policy Holder Name: _____

If Spouse DOB: _____ SSN: _____-_____-_____

Send results to: _____ OBGYN or Other: _____

Reason for visit today: _____

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 DISCLAIMER: **A quote of benefits does not guarantee payment or verify eligibility. Payment of benefits are subject to all terms, conditions, limitations, and exclusions of the member's contract at time of service.**

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 to 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 assist AWIC in providing my medical consultation, care and/or treatment.

X_____
Sign Patient/Legally Authorized Person/Financially Responsible Party **Date**