MORGAN HILL IMAGING

A Division of BASS Medical Group

16130 Juan Hernandez Drive., Ste 106 | Morgan Hill, CA 95037
Phone: (408) 465.2555 | Fax: (408) 465.2550

PATIENT INFORMATION		
Last Name:	First Name:	Middle:
SSN#:	DOB:	Gender:
Marital Status:	Emergency Contact Name:	Emergency Contact Phone: ( ) -
Address:		
City:	State:	Zip:
Home Phone: ( ) -	Cell Phone: ( ) -	Work Phone: ( ) -
Email Address:	By checking this box, you are authorizing us to send you statements, payment receipts or other billing information related to todays imaging services: ☐ Yes ☐ No	

PRIMARY INSURANCE		
Insurance Company:	ID#:	Group#:
Subscriber or Responsible Party Name:	DOB:	Relationship to Patient:

SECONDARY INSURANCE		
Insurance Company:	ID#:	Group#:
Subscriber or Responsible Party Name:	DOB:	Relationship to Patient:

SELF PAY OPTION: Please initial if you have health insurance but you do not want your insurance billed and instead opt to pay out of pocket as self-pay _____

ATTENTION MEDICARE PATIENTS ONLY: IF YOU ARE REFERRED BY A *CHIROPRACTOR* FOR RADIOLOGY SERVICES, PLEASE NOTE, MEDICARE WILL NOT COVER THE BILLED CHARGES.

FINANCIAL POLICY: Our office will verify your insurance eligibility; however, we cannot be held responsible for information received when verifying insurance benefits because it is not a guarantee of payment or eligibility. We will obtain an **ESTIMATE** of coverage and out-of-pocket fees from your insurance company prior to the service date. While we request an accurate estimate from your insurer, your final balance may differ from the estimate provided once insurance processes the claim. As a courtesy to you, our billing service (BASS MEDICAL GROUP) will submit your insurance claim(s) for imaging services rendered at this office. We will send a claim to any secondary insurance, if this is provided at the time of service. Please be advised that your insurance policy is a contract between you and your insurance company.

I, the undersigned, acknowledge that I understand the above, and agree to be financially responsible for any services I receive regardless of any insurance claim outcome. I further understand that final determination of my claim status is the sole responsibility of my insurance company. By signing below, I hereby authorize Bay Radiology San Ramon and the billing office of (BASS MEDICAL GROUP) to release all information necessary to secure payment from my insurance carrier(s). Notice of Privacy Practice available upon request.

_____ _____

Patient / Guarantor / Responsible Party Signature Date

BASS MEDICAL GROUP

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HIPAA Privacy Authorization Form

Authorization For Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

- I hereby authorize any insurance company, prepayment organization, employer, hospital, physician or utilization review representative to release to Bass Imaging and the billing office of (BASS MEDICAL GROUP) all information with respect to me and/or my dependent(s) which may have a bearing on any benefits payable from my insurance company for the procedure(s) performed by the facility on me or my dependent(s).

- I hereby authorize Bass Imaging and the billing office of (BASS MEDICAL GROUP) to release all information with respect to me and/or my dependent(s) which may have a bearing on either the procedure(s) provided or the benefits payable to me or my dependent(s): (I) to my insurance company, (II) to the physician or healthcare provider ordering/requesting the procedure(s), or (III) to Bass Imaging and the billing office of (BASS MEDICAL GROUP) for the purpose of demonstrating the existence of obligations of a governmental, commercial, or other payer to pay Bass Imaging and the billing office of (BASS MEDICAL GROUP) for services it performs on me or my dependent(s) behalf.

- I further consent and authorize Bass Imaging and the billing office of (BASS MEDICAL GROUP) to release any medical information it deems necessary to ensure the continuity of my medical care to any subsequent treating physician or facilities without further written consent by me.

- I agree that this authorization shall remain in effective for one (1) year from the date indicated below.

➢ Ok to release health information records or images to Family Member/Other listed below (optional):

Name & Relationship: _____

_____ _____

PRINT PATIENT NAME REPONSIBLE PARTY/GUARANTOR SIGNATURE

_____

DATE