

# ImageCare, LLC

710 Rabon Road  
Columbia, SC 29203

## PLEASE PRINT

PATIENT'S NAME: \_\_\_\_\_ SSN# \_\_\_\_\_ DOB: \_\_\_\_\_ SEX: \_\_\_\_\_  
*Last First Middle Init.*

MAILING ADDRESS: \_\_\_\_\_  
*Street Address City State Zip Home Phone*

RELATION TO INSURED: SELF \_\_\_\_\_ SPOUSE \_\_\_\_\_ CHILD \_\_\_\_\_ OTHER \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_  
*Name Phone #*

INSURANCE COMPANY (1): \_\_\_\_\_  
*(Primary) Name Group# Insurance ID #*

INSURED'S NAME: \_\_\_\_\_ SSN#: \_\_\_\_\_ D.O.B. \_\_\_\_\_

INSURANCE COMPANY (2): \_\_\_\_\_  
*(Secondary) Name Group# Insurance ID #*

INSURED'S NAME: \_\_\_\_\_ SSN#: \_\_\_\_\_ D.O.B. \_\_\_\_\_

INSURED'S EMPLOYER: \_\_\_\_\_ PHONE# (WORK) (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

PHONE# (HOME) (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

### ALL PATIENTS

I authorize you or your duly authorized agents to release information to my insurance carrier relative to any claim(s) I may incur. This permission is granted on my behalf for my lifetime. I understand that even though I may have some type of insurance coverage, I am responsible for payment of services. I hereby give permission for my insurance company to pay ImageCare, L.L.C. directly. In assigned cases the doctor agrees to the charge determination of the Medicare carrier as the full charge for covered services. The patient is responsible only for the deductible, co-insurance and non-covered services. This permission is granted on my behalf for my lifetime.

SIGNATURE OF PATIENT: \_\_\_\_\_ DATE: \_\_\_\_\_

### MEDICARE PATIENTS ONLY

I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to ImageCare, L.L.C.. I understand this is a lifetime authorization to be used for this and any subsequent claims.

SIGNATURE OF PATIENT: \_\_\_\_\_ DATE: \_\_\_\_\_

### COMMENTS:

Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to Medicare, your health information on this form may be shared with Medicare. Your health information that Medicare sees will be kept confidential by Medicare.

I have been given a copy of ImageCare's Notice of Privacy Practices: Initials \_\_\_\_\_ Date: \_\_\_\_\_

1. Any chance of pregnancy? \_\_\_\_\_ Yes \_\_\_\_\_ No

2. How did you hear about ImageCare? (Please Circle One) Referred by MD or friend, TV, Newspaper, Magazine:  
Which One? \_\_\_\_\_ Other \_\_\_\_\_