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* **Telephone**

RACE: ____________ **RELATION TO INSURED:** **SELF:** _____ **SPOUSE:** ______ **CHILD:** ______ **OTHER:** ______

EMERGENCY CONTACT: ____
Name *Phone #*

RELEASE: I, ___________________________________, give the family member named below permission granted on my behalf and for my lifetime to obtain all/any of my medical records performed at ImageCare, LCC. This can only be changed/revoked upon written request by the patient. All previously released records will not apply.

Name: ____ **Date of Birth:** ______________________________
Please Print

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

INSURED'S NAME: ____________________________________ **SSN#:** ______________________ **DOB:** ________

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

INSURED'S NAME: ____________________________________ **SSN#:** ______________________ **DOB:** ________

PATIENT/GUARDIAN EMAIL: ______________________________ **PHONE# (WORK):** (______) ______-______________

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. I understand that even though I may have some type of insurance coverage, I am responsible for payment services. I hereby give permission for my insurance company to pay ImageCare, LLC. 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, LLC. I understand that 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:** ______________

Any chance of pregnancy? ________**Yes** __________**No**