THE IMAGING CENTER OF LAS CRUCES RADIOLOGY

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WHERE YOU ARE OUR FOCUS

Ramakrishna Devasthali, M.D. Puneet Ghei, M.D.
Biren Shah, M.D.

PATIENT INFORMATION/CONSENT FORM

Please Print

Patient Name: _____ Sex: M F Birth Date: _____

Area of Exam (s):_____ L R Referring Physician: _____

S.S. #_____ Phone H _____ W _____ C _____

Mailing Address: _____ City: _____

State: _____ Zip Code: _____

Street Address: _____ Marital Status: S M W D

Employer: _____ Occupation: _____

Policyholder s Name:_____ Birth Date: _____ S.S. # _____

Policyholder s Employer:_____ Relationship to Patient: _____

1._____ Consent for Diagnostic Procedures(s):
It is understood that the diagnostic procedure(s) prescribed by my physician will be performed by the center personnel and do hereby authorize and consent to such service and procedure(s). I further certify that no guarantee of assurance has been made as to the results which may be obtained.

2._____ Release of Medical Information:
I hereby authorize LCI/LCRA to release any medical information regarding the services performed to my personal physician, or other physicians as requested by my personal physician, insurance company or employer (in the event of a worker s compensation injury). A 24 hour notice is required.

3._____ Assignment of Insurance Benefits:
I hereby assign all benefits due me by the named insurance company and any third party payer to be paid directly to LCI/ LCRA.

PATIENT'S RIGHTS OBTAINED

4._____ Financial Agreement:
The undersigned hereby agrees to pay all charges not covered by named insurances rendered by LCI/LCRA. Any balance not paid within sixty (60) days after the date of service will be considered in default unless financial arrangements have been made with the business office administrator or designee. The undersigned certifies that he/she has read the foregoing thereof and is the patient or is duly authorized by the patient as the patient s general agent to execute the above and accepts its item.

5._____Two Separate Bills:
I understand that I will receive two separate bills from our billing service, one from LCI for the technical service(s) and another from LCRA for the professional service(s).

6._____ Personal Valuables:
Keep all valuables with you at all times. LCI/LCRA is not responsible for any lost items.

_____ _____
Date Patient s Signature

_____ _____
Relationship to patient Patient s parent or guardian

_____ _____
Date Witness

_____
If patient is unable to sign, please give reason