

Arizona Pain Specialists/Valley MRI & Radiology
9787 N. 91st Street, Suite 101
Scottsdale, Az. 85258

Insurance Information

Patient Information

Name of Patient

Date of Birth

Address

Social Security No.

Telephone

Policy Holder Information

Name of Policy Holder

Date of Birth

Address

Employer

Social Security No.

Telephone

Primary Insurance Information

Primary Insurance

Address

Group No.

Policy/I.D. No.

Treatment Auth. No.

Secondary Insurance Information

Secondary Insurance

Address

Group No.

Policy/I.D. No.

Treatment Auth. No.

AUTHORIZATION FOR TREATMENT AND FINANCIAL AGREEMENT: I authorize treatment of the person named above and agree to pay all fees and charges for such treatment, promptly upon presentation of statement, unless prior credit arrangements have been agreed upon in writing. Charges shown by statement are agreed to be correct and reasonable unless protested in writing within thirty (30) days of the billing date. Although this office may assist me in filing an insurance claim, I understand that I am fully responsible for the balance and agree that payment will not be delayed because of any pending insurance claim. In the event legal action should become necessary to collect an unpaid balance, I agree to pay all reasonable attorney's fees or other costs the court may determine proper.

ASSIGNMENT OF BENEFITS AND AUTHORIZATION TO RELEASE INFORMATION: I authorize all insurance benefits, unless previously paid by myself, to be paid directly to this physician/facility and also authorize the physician/facility to release any information required in the processing of the insurance claim. I authorize the physician/facility to release medical information to my referring physician, primary care physician, spouse, children, parents and any physician he/she may refer me to.

Signed: _____ (Patient) Date: _____

ALL MEDICARE PATIENTS MUST SIGN THE FOLLOWING STATEMENT: I request that payment under the medical insurance program be made on my behalf to AZ Pain Specialists/Valley MRI for any services furnished me by its physician(s) and/or practitioners. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I permit a copy of this authorization to be used in place of the original.

Signed: _____ Date: _____