ROSETTA

advanced imaging • radiation oncology
diagnostic radiology • women's imaging

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APPOINTMENT TIME **PROCEDURE** **NP/OP**

PLEASE PRINT DATE _____

PATIENT NAME _____

STREET ADDRESS_____APT#_____DATE OF BIRTH:_____

CITY, STATE, ZIP_____HOME#_____

WORK#_____

CELL#_____

INSURANCE PLAN:_____

ID#:_____

POLICY HOLDER IF OTHER THAN PATIENT_____

RELATIONSHIP TO PATIENT:_____

STREET ADDRESS_____APT#_____DATE OF BIRTH:_____

CITY, STATE, ZIP_____HOME#:_____

REFERRING DRS NAME & ADDRESS_____

OTHER TO RECEIVE REPORTS: DR_____

STREET ADDRESS, CITY, STATE, ZIP_____

DR_____

STREET ADDRESS, CITY, STATE, ZIP_____

I authorize the release of any medical or other information necessary to process this claim. I agree to pay for all medical services rendered, including all bills not covered by my insurance. I authorize payment of medical benefits to the above listed physicians.
As required by HIPPA we will use your medical records only for treatment, and healthcare operations.

Signed_____Date_____