DOCTORS GROOVER CHRISTIE & MERRITT
RADIOLOGISTS

Advancing Medical Imaging Since 1916

PATIENT INFORMATION

NAME: _____
First Middle Last

ADDRESS: _____
Street Apt. No.

_____
City State Zip

HOME PHONE: _____ ALTERNATE NUMBER: _____

DATE OF BIRTH: _____ SOCIAL SECURITY #: _____-_____-_____

GENDER: ☐ MALE ☐ FEMALE

REFERRING PHYSICIAN: _____ PHONE: _____

ADDRESS: _____
Street Suite

_____
City State Zip

CONSENT TO PERFORM SERVICES AND AUTHORIZATION TO APPLY FOR BENEFITS AND RELEASE REQUIRED INFORMATION

I give my consent to Drs. Groover, Christie and Merritt (GCM) to perform services requested by my physician. I authorize GCM to apply for benefits on my behalf for services provided. I request that payments of benefits authorized by Medicare, Blue Shield, other third-party carriers (Medigap) or governmental agencies, be made directly to GCM.

I authorize the release of medical information relevant to these services when required by Health Care Financial Administration (HCFA), its agents, insurance carriers, including any Medigap insurer indicated in the column below, for determining eligibility of benefits. GCM, its agent and employees are released from all liability that may arise from the release of such information.

I guarantee prompt payment of all costs associated with services rendered by GCM, which are not covered by insurance. If any of these charges are referred to an attorney for collection, I agree to pay reasonable legal fees, court cost and collection expenses. Any account balance remaining unpaid after 90 days, for which I am personally responsible, may accrue an interest charge on the unpaid balance at a rate permitted by applicable law.

_____ _____
Signature of Patient Date

_____ _____
Signature of Witness Date

_____ _____
Responsible Party Date