

**Clinical P.E.T. of West County**  
**ASSIGNMENT OF BENEFITS & RELEASE OF INFORMATION**

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Patient Name \_\_\_\_\_

Street \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Phone: Home \_\_\_\_\_

Work \_\_\_\_\_

Soc. Sec. No. \_\_\_\_\_ DOB \_\_\_\_\_

Sex \_\_\_ Marital Status \_\_\_\_\_ Age \_\_\_\_\_

Employer's Name \_\_\_\_\_

Street \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Previous Patient to our facility?

YES \_\_\_ NO \_\_\_ Date \_\_\_\_\_

Referring Physician \_\_\_\_\_

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Responsible Party Name: \_\_\_\_\_

Street \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Phone: Home \_\_\_\_\_

Work \_\_\_\_\_

Soc. Sec. No. \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Employer's Name \_\_\_\_\_

Street \_\_\_\_\_

City/State/Zip \_\_\_\_\_

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**INSURANCE INFORMATION**

**Primary**

Name \_\_\_\_\_

Street \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Subscriber's Name \_\_\_\_\_

Relationship to Subscriber \_\_\_\_\_

Policy # \_\_\_\_\_

Group Name & # \_\_\_\_\_

Pre-authorization # \_\_\_\_\_

Phone # \_\_\_\_\_

**Secondary**

Name \_\_\_\_\_

Street \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Subscriber's Name \_\_\_\_\_

Relationship to Subscriber \_\_\_\_\_

Policy # \_\_\_\_\_

Group Name & # \_\_\_\_\_

Pre-authorization # \_\_\_\_\_

Phone # \_\_\_\_\_

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**EMERGENCY CONTACT OTHER THAN SPOUSE OR RESPONSIBLE PARTY**

Name \_\_\_\_\_

Phone # \_\_\_\_\_

Relationship \_\_\_\_\_

Name \_\_\_\_\_

Phone # \_\_\_\_\_

Relationship \_\_\_\_\_

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I AGREE THAT MY MEDICAL RECORDS MAY BE SUBJECT TO REVIEW AND THAT ANY INFORMATION OBTAINED FROM SUCH A REVIEW MAY BE FORWARDED TO MY INSURANCE COMPANY OR OTHER THIRD PARTY REPRESENTATIVE. I AUTHORIZE MISSOURI IMAGING AFFILIATES, L.L.C., TO RELEASE MY MEDICAL RECORDS FOR INSURANCE PURPOSES.

I HEREBY REQUEST AND AUTHORIZE THE INSURANCE COMPANY TO PAY DIRECTLY TO MISSOURI IMAGING AFFILIATES, L.L.C. ANY MEDICAL BENEFITS OR PROCEEDS PAYABLE UNDER THE TERMS OF THE CURRENT POLICY NUMBER. IN MAKING THIS ASSIGNMENT, I UNDERSTAND AND AGREE ANY UNPAID BALANCE NOT COVERED BY THIS POLICY AND MEDICAID, WILL BE PAID BY ME.

I hereby acknowledge receipt of the Notice of Privacy Practices from Clinical P.E.T. of West County dated April 14, 2003.

SIGNED \_\_\_\_\_ DATE \_\_\_\_\_

Patient or Parent/Legal Guardian