Medical X-Ray Consultants
Interventional Radiology

Name: ____ Today's Date: _________________
First Middle Last

Home Address: ____
City: ____________________________________ State: __________ Zip: ______________
Home Phone: ( )____________________ Cell/Work Phone: ( ) ___________________
SSN: ___________________________ Birth Date: ________________________________
Occupation: ___________________________ Employer:_________________________________
Primary Physician: ____________________________ Phone Number: ( ) _________________

Name of Spouse: ______________________ Employer: ______________________________
Birth Date: ______________________________

Emergency, contact: __________________________________ Relationship: ______________
Home Phone: ( ) ____________________ Cell/Work Phone: ( ) ___________________

Complete this section only if someone other than the patient is financially responsible.
Responsible Party: ______________________________ Relationship to Patient: ____________
Home Address: ____
City: ____________________________________ State: __________ Zip: ______________
Telephone: ( ) _____________________ Cell/Work Phone: ( ) ____________________
SSN: ___________________________ Birth Date: ________________________________
Employer: _____________________________________

Do you believe payment for your services is to be covered by Worker's Compensation? _________

How did you learn about our practice?

- ☐ I found you in the Yellow Pages.
- ☐ I found your Web site on the Internet.
- ☐ The hospital call center recommended you.
- ☐ You were in my managed care plan book.
- ☐ Direct Mailing.
- ☐ Newspaper/Magazine:_________________________
- ☐ Dr. ________________________________
- ☐ My friend, ___________________________
- ☐ At a seminar. Where? ___________________
- ☐ Television. Channel:___________________
- ☐ Radio. Station:_______________________
- ☐ Other: ______________________________

I hereby authorize Chippewa Valley Vein Center to bill and receive payment directly from my insurance for services rendered or products purchased. It is also understood that any medical and/or other information necessary to process this claim will be released upon request from the insurance carrier.
I further acknowledge that the service(s) and/or items(s) may not be a covered benefit by my insurance plan. Every effort will be made to my insurer for reimbursement and in the event of insurance denial to pay I agree to be responsible for the full amount of the billed charges or the remaining balance after my insurer has paid. This consent is valid until/unless revoked in writing. I request that payment of authorized Medicare benefits be made on my behalf to The Chippewa Valley Vein Center for any services furnished me by that provider. I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

Patients Signature: ____________________________________ Date: ___________________

Parent or Guardian Signature: ____________________________ Date: ___________________

Please present your current insurance card to the receptionist with this form.