

CYRUS DIAGNOSTIC IMAGING, INC.

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1-800-759-6682

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www.cyrusdiagnostic.com

Patient Name: _____ Date: _____ Tape#: _____
Address: _____ City: _____ State: _____ Zip _____
Age: _____ Date of Birth: _____ Sex: _____ Social Security: _____
Home Phone: _____ Work Phone: _____
Employer Name: _____ Employer Address: _____ Zip: _____
Ordering Physician: _____ Interpreting Physician: _____ Technician: _____

Responsible Party other than patient

Name: _____ Phone: _____ Date: _____
Address: _____ City: _____ State: _____ Zip _____

Primary Insurance

Insurance Company Name: _____
Address: _____ City: _____ State: _____ Zip _____
Policy# _____ Group# _____ Plan# _____ Insured's S.S.# _____
Insured's Name: _____ Relationship to patient: _____

Secondary Insurance

Insurance Company Name: _____
Address: _____ City: _____ State: _____ Zip _____
Policy# _____ Group# _____ Plan# _____ Insured's S.S.# _____
Insured's Name: _____ Relationship to patient: _____

I understand I am financially responsible for all charges, whether or not paid by said insurance. It is my responsibility to pay any deductible amount or any other balance not paid for by my insurance in 30 days.

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patients records.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

I authorize the release of any medical information necessary to process this claim and request payment of medical benefits to Cyrus Diagnostic Imaging, Inc. who accepts assignment.

Signed: _____ Date: _____