



Financial Responsibility Acknowledgement

Patient Name: _____ DOB: _____

Address _____

Home Phone: _____ Work Phone: _____

Responsible Party Name: _____

Address (if different from above): _____

Physician Name: _____

Physician Address: _____

Primary Insurance: _____

The following is our Financial Policy.

- Desert Radiologists will bill your insurance carrier for you.
- Patient/insured assigns all insurance benefits to Desert Radiologists for services provided today.
- Patient/insured assumes and agrees to pay all applicable deductibles, coinsurances and co-pays.
- Patient/insured agrees to pay for all non-covered services (preventive, screening or routine) that are not covered by the insurance company.
- Patient/insured understands that all returned checks are subject to a return check fee of \$25.00.
- Desert Radiologists will accept payment by cash, check, or for your convenience any type of credit/ATM card.
- Patient/insured is advised that Desert Radiologists is contracted with an outside billing service. Zotec will provide billing statements; they can be reached at (866) 750-3229.

I further understand that it is my responsibility to follow up with my referring physician regarding my test/biopsy results.

Patient/Insured Signature

Date



Patient Name: _____ DOB: _____

Standard Authorization of Use and Disclosure of Protected Health Information

I authorize Desert Radiologists the use and disclosure of Protected Health Information. My personal identifying information is as listed above. The information to be used and disclosed covered by this authorization includes: medical records, films, billing information, etc.

Family Member/Persons/Group to whom information may be disclosed: (Name / Address / Phone or Fax #)

The Protected Health Information will be Used and Disclosed as follows: (check box that applies)

At the request of the patient Other _____

This authorization is effective through _____ (mm/dd/yyyy) unless revoked or terminated by the patient or the patient’s personal representative. You may revoke or terminate this authorization by submitting a written revocation to Desert Radiologists. You should contact the Compliance Department (702/759-8760) to terminate this authorization. Revocation will exclude disclosures made prior to effective date of revocation. Please note that the person or organization to which we disclose PHI may further disclose information that is disclosed under this authorization. The privacy of this information may not be protected under the federal privacy regulations.

Request for Protected Health Information from another Provider
(Privacy Rule 45 CFR 164.506)

In an effort to obtain continuation of care with out any delay, I authorize the following health care providers to release any and all necessary health care information to Desert Radiologists:

_____ **Provider Name**

_____ **Provider Address**

_____ **Provider Phone number and Fax number**

Please send records to the medical records department at:

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> 2020 Palomino Lane
#100
Las Vegas, NV 89106
P (702) 759-8750
F (702) 598-1094 | <input type="checkbox"/> 3920 S. Eastern Ave.
#100
Las Vegas, NV 89119
P (702) 794-2101 F (702)
794-2104 | <input type="checkbox"/> 7200 Cathedral Rock Dr.
#230
Las Vegas, NV 89128
P (702) 759-4310
F (702) 562-2157 | <input type="checkbox"/> 2811 W. Horizon Ridge
Pkwy
Henderson, NV 89052
P (702) 759-4500
F (702) 616-1175 |
|--|--|---|---|

Desert Radiologists will not condition treatment on whether the patient signs this authorization unless the treatment is research related or the treatment is for the purpose of creating PHI for disclosure to a third party such as life insurance or for disability examinations.

Signature of Patient/Patient’s Representative _____
Date

Relationship to Patient