BAY RADIOLOGY
San Ramon
A Division of BASS Medical Group

2242 Camino Ramon., Ste 100 | San Ramon CA, 94583
Phone: (925) 327.0015 | Fax: (925) 327.0095

PATIENT INFORMATION		
Last Name:	First Name:	Middle:
SSN#:	DOB:	Gender:
Marital Status:	Emergency Contact:	Phone: ( ) -
Address:		
City:	State:	Zip:
Home Phone: ( ) -	Cell Phone: ( ) -	Work Phone: ( ) -
Email Address:	By checking this box, you are authorizing us to send you statements, payment receipts or other billing information related to todays imaging services: ☐Yes ☐ No	

PRIMARY INSURANCE		
Insurance Company:	ID#:	Group#:
Subscriber or Responsible Party Name:	DOB:	Relationship to Patient:

SECONDARY INSURANCE		
Insurance Company:	ID#:	Group#:
Subscriber or Responsible Party Name:	DOB:	Relationship to Patient:

ATTENTION MEDICARE PATIENTS ONLY: IF YOU ARE REFERRED BY A *CHIROPRACTOR* FOR RADIOLOGY SERVICES, PLEASE NOTE, MEDICARE WILL NOT COVER THE BILLED CHARGES.

FINANCIAL POLICY: Our office will verify your insurance eligibility; however, we cannot be held responsible for information received when verifying insurance benefits because it is not a guarantee of payment or eligibility. We will obtain an **ESTIMATE** of coverage and out-of-pocket fees from your insurance company prior to the service date. While we request an accurate estimate from your insurer, your final balance may differ from the estimate provided once insurance processes the claim. As a courtesy to you, our billing service (BASS MEDICAL GROUP) will submit your insurance claim(s) for imaging services rendered at this office. We will send a claim to any secondary insurance, if this is provided at the time of service. Please be advised that your insurance policy is a contract between you and your insurance company.

I, the undersigned, acknowledge that I understand the above, and agree to be financially responsible for any services I receive regardless of any insurance claim outcome. I further understand that final determination of my claim status is the sole responsibility of my insurance company.

By signing below, I hereby authorize Bay Radiology San Ramon and the billing office of (BASS MEDICAL GROUP) to release all information necessary to secure payment from my insurance carrier(s). Notice of Privacy Practice available upon request.

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Patient / Guarantor / Responsible Party Signature Date