MedWise, PC

(an affiliate of Radiology Ltd)

PATIENT ENROLLMENT

(MRN# __________)

☐ I HEREBY ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THE MEDWISE NOTICE OF PRIVACY PRACTICES. __________ (Initial)

PATIENT INFORMATION:

Last Name ______ First Name ______ MI ______ Date of Birth ___/___/___ Sex: M / F

Mailing Address ______ City ______ State ______ Zip ______

Physical Address (required if mailing address is a PO Box) ______ City ______ State ______ Zip ______

(____) ______ Home Phone (____) ______ Cell Phone (____) ______ Work Phone May we contact you at work? Y ☐ N ☐

Marital Status: S / M / D / W Full time Student ☐ Part time Student ☐ Name of School: ______

GUARANTOR INFORMATION: (*COMPLETE FOR MINOR PATIENTS ONLY*) *note: custodial parent will be billed

Name ______ Relation to Patient ______ Date of Birth ___/___/___ Sex: M / F

Mailing Address (if different from above) ______ City ______ State ______ Zip ______ (____) ______ Home Phone

Guarantor Employer ______ (____) ______ Work Phone (____) ______ Cell Phone

INSURANCE INFORMATION – ALL PATIENTS MUST COMPLETE THIS SECTION

(IF ACCIDENT IS WORK, AUTO OR LIABILITY RELATED MUST ALSO COMPLETE SECTION ON BACK OF FORM)

Health Insurance information required on all workers compensation and auto/liability claims in case of claim denial

Primary Insurance Carrier ______ Name of Policy Holder/Subscriber ______ Date of Birth ___/___/___ Relationship to Patient ______

ID#: ______ ☐ Copy of card provided Employer Name of Subscriber ______

Secondary Insurance Carrier ______ Name of Policy Holder/Subscriber ______ Date of Birth ___/___/___ Relationship to Patient ______

ID#: ______ ☐ Copy of card provided Employer Name of Subscriber ______

Accident or Injury Related? ☐Yes ☐No Date of Injury: ______ ☐ WORK ☐AUTO ☐ OTHER______

FAMILY, CAREGIVERS AND/OR PATIENT REPRESENTATIVES WHO HAVE PERMISSION TO RECEIVE PROTECTED HEALTH INFORMATION ON BEHALF OF THE PATIENT (they must be listed here if they will be picking up ANY medical records)

1. ______ Print Name
   ______ Relationship to Patient
2. ______ Print Name
   ______ Relationship to Patient
3. ______ Print Name
   ______ Relationship to Patient

PERSON, NOT LIVING WITH YOU, TO NOTIFY IN CASE OF EMERGENCY:

Name ______ Relationship ______ (____) ______ Home phone (____) ______ Cell phone

Please turn over→

CLAIM INFORMATION FOR WORK INJURY

Employer at time of Injury	( ) Phone Number	/ / Date of Injury	Claim Number

City and State Where Injured	Employer's Insurance Carrier	Claim Representative

Mailing Address for Claims	City	State	Zip	( ) WC Insurance Phone Number

CLAIM INFORMATION FOR AUTO OR OTHER LIABILITY INJURIES

MedWise does not bill Third Party Insurance Companies. We will bill YOUR motor vehicle insurance carrier only if you have effective MedPay coverage. Health insurance rules and regulations must be complied with for all auto accidents in the event the claim is denied or MedPay exhausted. Please speak to a billing representative for questions.

Name of Insurance Carrier	Claim Representative or Adjustor (not agent)	Claim Number

Mailing Address for Claims	City	State	Zip	( ) Phone Number

AUTHORIZATION & RELEASE (must be signed by patient or guardian in order for treatment)

I AUTHORIZE SERVICES TO BE PROVIDED BY MEDWISE, PC an affiliate of Radiology Ltd, AND REQUEST THAT PAYMENT OF ANY INSURANCE BENEFITS BE MADE PAYABLE TO RADIOLOGY LTD. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR ANY AND ALL SERVICES NOT COVERED BY ANY HEALTH INSURANCE OR OTHER MEDICAL, AUTO OR WORKERS COMPENSATION BENEFIT PLANS. I AM ALSO RESPONSIBLE FOR ENSURING PREAUTHORIZATION AND NETWORK REQUIREMENTS ARE FULFILLED.

I AGREE AS FOLLOWS: a) TO PAY ALL COSTS OF COLLECTING ANY DEBT I INCUR, INCLUDING REASONABLE ATTORNEY'S FEES; b) THAT ALL DEBTS I INCUR (INCLUDING COLLECTION COSTS AND ATTORNEY'S FEES) SHALL ACCRUE INTEREST AT THE RATE OF EIGHTEEN PERCENT (18%) PER ANNUM FROM THE DATE OF FIRST BILLING UNTIL PAID IN FULL; c) THAT A CONSUMER INFORMATION REPORT REGARDING ME MAY BE OBTAINED BY MEDWISE-RADIOLOGY LTD OR ITS AGENTS IF MY DEBT IS NOT PAID WHEN DUE; AND d) THAT NO SET-OFF, OFFSET, COUNTERCLAIM OR RECOUPMENT SHALL BE ALLOWED AGAINST ANY DEBT I INCUR AS A RESULT OF SERVICES PROVIDED. I ALSO UNDERSTAND THAT I AM ENTITLED TO OBTAIN ANY ESTIMATED COSTS PRIOR TO TREATMENT AT MEDWISE PC AND OR RADIOLOGY LTD AND THAT APPROPRIATE FINANCIAL ARRANGEMENTS MAY BE AGREED TO BY ME WITH MEDWISE PC AND RADIOLOGY LTD. ALL PATIENT BALANCES ARE DUE AND PAYABLE AT THE TIME OF FIRST STATEMENT UNLESS SUPERCEDED BY A SIGNED FINANCIAL AGREEMENT.

PATIENT OR RESPONSIBLE PARTY SIGNATURE ______________________ **DATE** __________

New Patients: How did you hear about MedWise?

☐ **Friend** ☐ **Health Care Provider** ☐ **Newspaper** ☐ **Yellow Pages** ☐ **Other:** ____________________

MedWise Staff front desk__________________