

Appointment Date:

Last Name	First Name	MI	Date of Birth	Male	Female
Street Address				Height	Weight
City	Zip Code	Preferred Email Address			
Social Security #	Home Phone	Work Phone	Cell Phone		
Employer Name					
Insured's Name		Insured's Employer		Relationship to Patient	
Insurance		ID#			
Secondary Insurance		Secondary ID#		Secondary Insured's DOB	

Are you here as the result of a car accident?	Yes	No	
	<input type="checkbox"/>	<input type="checkbox"/>	
Are you here as the result of a work related	<input type="checkbox"/>	<input type="checkbox"/>	

- Why did you choose Zwanger-Pesiri Radiology?**
- A) Friend/Family Member Recommendation
 - B) Doctor Referral
 - C) Advertisement (Radio, Newspaper, Etc.)
 - D) Convenience (Hours, location, etc.)

Patient Name _____ Date _____

Yes No

Does your insurance have a deductible?

Do you have an HSA or HRA plan?

If yes, we need a copy of your debit card.

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

Authorization for Treatment: I hereby consent to treatment by the radiologist and other medical staff for all local anesthetics, radiologic tests and/or procedures as deemed necessary by myself and the Zwanger-Pesiri Radiology staff:

I am aware that additional charges may be incurred if a diagnostic mammogram is deemed necessary. I understand that according to my particular insurance plan, this may or may not be covered.

Authorization for Release of Information and Assignment of Benefits: I hereby assign to Zwanger-Pesiri Radiology, LLP those benefits otherwise payable to me by any third party as reimbursement of expenses and fees in connection with testing performed and treatment rendered. I request that payment of authorized benefits be made directly to Zwanger-Pesiri Radiology on my behalf. I fully understand that I am financially responsible for **any** and **all** amounts not otherwise paid by my insurance carrier:

I certify that the information on this form given by me for payment under Title XVIII(Medicare) is correct and complete. I authorize holder of medical or related information about me to be released to the Health Care Financial Administration (HCFA) and/or other health care coverage entity, any information needed of this or any related healthcare claim in writing or verbally. I further understand and agree to pay for services or amounts due when denied as not covered by Medicare or any other health insurance plans

I hereby authorize release of my films, images, reports and medical records as needed for subsequent medical care. In event of positive findings I authorize release of my results to my referring and treating physicians for their records.

I acknowledge that I have been provided with a copy of the Zwanger-Pesiri Radiology's Notice of Privacy Practices. In addition, I give the right for Zwanger-Pesiri Radiology, LLP to contact the following person(s) to discuss medical treatment and/or billing information:

Persons(s)	Relationship	Phone#
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This authorization will remain in effect unless changed by me, while I am a patient of Zwanger-Pesiri Radiology, LLP.

Pregnancy Denial Statement

Women age 12-55 (except ultrasound)

I hereby attest that there is **NO** possibility that I am pregnant.

Patient signature

Patient Name _____ Date _____

Biopsy Consent

I hereby Authorize: Dr. Dorfman / Dr. Settle / Dr. Tamarkin / Dr. Baran / Dr. Elkowitz / Dr. Obedian
To perform the following procedure upon me:

- Ultrasound Guided Core Breast Biopsy with possible placement of a clip
- Ultrasound Guided Breast Aspiration
- Stereotactic Breast Biopsy with possible placement of a clip
- Ultrasound Guided Thyroid Biopsy/Aspiration
- MRI Guided Breast Biopsy
- CT Guided Biopsy

Explanation of procedure, risks, benefits and alternatives:

The above radiologist has explained to me the nature and purpose of the procedure and has also informed me of expected benefits and complications, attendant discomforts and risks that may arise, as well as possible alternative methods of diagnosis and/or treatment. I have been given an opportunity to ask questions and all my questions have been answered satisfactorily.

I further consent to the administration of such anesthesia, as may be considered necessary or desirable in the judgment of the radiologist.

I confirm that I have read this form and understand its contents.

Signature (patient, relative, guardian)

Print name

Date

Witness: _____

Physicians Statement of Informed Consent:

I hereby certify that I have explained the nature, purpose, benefits, risks and alternatives of the above stated procedure and have offered to answer any questions. I have answered all such questions and believe that the patient (relative or guardian) understands what I have explained and answered:

Radiologist

Please sign here



I understand that payment is due at the time of service and that I am financially responsible for **ANY** and **ALL** amounts not otherwise paid by my insurance carrier.

I UNDERSTAND THAT MY ACCOUNT WILL BE SUBJECT TO AN ADDITIONAL \$15.00 PROCESSING FEE EACH MONTH IF PAYMENT IS NOT RECEIVED BY THE DUE DATE INDICATED ON MY BILLING STATEMENT.

I **further attest** that the information I have provided on these **forms** are true to the best of my knowledge

Patient or Legal Guardian Signature

Date