1640 Hospital Drive, Santa Fe, NM 87505 ▪ TEL: 505-983-9350
Scheduling FAX: 505-954-4253 ▪ Med Records FAX: 505-986-0859

NOTE: Areas highlighted in yellow MUST be Completed (ask Registration desk staff for help if needed)

Patient Information (Please Print)

Patient Last Name		Patient First Name	
Gender: Male☐ Female☐	Social Security Number	Date Of Birth	
Mailing Address	Zip	City	State
Phone Number(s): (H)	(W)	(C)	
Patient Employer		Employer Address	
Zip	City	State	Phone Number

Referring Physician	Primary Physician	Reason for Visit
Is this related to an Accident: Yes☐ No☐	Type: Auto ☐ Employment ☐ Other☐	Date of Accident

Must be completed if: Patient is under 18yrs of age and/or is not the Insurance Policy Holder

Guarantor Last, First Name		Relationship to Patient	
Gender: Male☐ Female☐	Social Security Number	Date Of Birth	
Mailing Address	Zip	City	State
Guarantor Employer		Employer Address	
Zip	City	State	Phone Number

Primary Insurance	Secondary Insurance	Tertiary Insurance

Emergency Contact Last Name	Emergency Contact First Name
Relation to Patient	Phone Number

Possibility of Pregnancy: Yes☐ No☐	Diabetic: Yes ☐ No☐	Have you been at SFI before? : Yes ☐ No☐

Note: See reverse side and attached paper work.

ASSIGNMENT OF BENEFITS AND AUTHORIZATION FOR TREATMENT
PLEASE READ AND INITIAL APPROPRIATE BOXES

NOTE: Areas highlighted in yellow MUST be Completed (ask Registration desk staff for help if needed)

________ **CONSENT FOR MEDICAL AND SURGICAL TREATMENT:** I authorize Santa Fe Imaging, LLC to furnish the necessary medical or surgical treatments, or procedures, including diagnostic, x-ray, and laboratory procedures, anesthesia, drugs and supplies as may be ordered by the attending physician(s), his assistants or his designees. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatment, diagnostic procedures in Santa Fe Imaging, LLC. I recognize that the physicians who practice at Santa Fe Imaging, LLC are not employees or agents of Santa Fe Imaging, LLC but are independent physicians. Santa Fe Imaging, LLC may delegate to these independent physicians those services physicians normally provide, and any questions relating to care my physician has given or ordered should be directed to him/her.

________ **ASSIGNMENT OF BENEFITS:** I hereby authorize payment directly to Santa Fe Imaging, LLC of any and all medical benefits applicable and otherwise payable to me. I understand that I am financially responsible to Santa Fe Imaging, LLC for charges not covered by this assignment. I also understand that Santa Fe Imaging, LLC is filing my claims as a courtesy to me and that unless stipulated in a contract with my carrier, I am responsible for payment of this claims.

________ **AUTHORIZATION FOR RELEASE OF INFORMATION:** I hereby authorize Santa Fe Imaging, LLC to release any information including information regarding diagnosis and treatment requested by the insurance company/doctor/hospital necessary to collect benefits under the policies started at the time of treatment, or any policies which I subsequently make claim against for hospital services, including related physicians' services on this or related date of service. Unless noted below, this authorization includes but is not limited to, the release of information related to drug, alcohol, HIV antibody and/or psychiatric treatment and/or testing. Withhold from release: _______________________ I further authorize any physician or institution that attended this patient previously to furnish medical records or information which may be requested by Santa Fe Imaging, LLC or attending physician.____

________ **LIFETIME MEDICARE B SIGNATURE AUTHORIZATION:** I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers, or to the billing agent of Santa Fe Imaging, LLC, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical benefits to be made to the holder of the assignment on my behalf. I understand that I am responsible for any health deductibles and coinsurance. NOTE: MEDICARE WILL ONLY PAY FOR A ROUTINE MAMMOGRAM EVERY 12 MONTHS.

MEDIGAP: I request that payment of authorized Medigap benefits be made on by behalf to Santa Fe Imaging, LLC for any services furnished to me by them. I authorize any holder of medical information about me to release to _______________ any information needed to determine these benefits or benefits payable for related services. I understand that I do not need to provide my supplemental insurer with information concerning this Medicare claim, because my signing this authorization will cause Medicare payment to cross over automatically.

NAME OF INSURED: ____

MEDIGAP POLICY COMPANY: ____ POLICY NUMBER: __________________________________

LIABILITY / INSURANCE WAIVER: I hereby state that I wish Santa Fe Imaging, LLC ,to submit my claim for medical services to:

____ for services rendered for the accident date of: ________________________________

I am not filing this claim with any other liability insurance and will not be making any claim to any other general liability insurance or company. I also understand that if I do submit this to any other general liability insurance or company that ______________________________ will have to be refunded immediately and the total amount originally charged for the services rendered will become due and payable by me. Filing your liability insurance does not constitute an assignment. If this is a legal case, we do not accept assignment pending the outcome of your case. You are responsible for your bill in its entirety.

________ **LIABILITY/ATTORNEY-MEDICAL RECORDS RELEASE:** I authorize Santa Fe Imaging, LLC to release my medical records to my attorney:

Name ____ Phone Number: ________________________________

Address: ____

________ **WORKER'S COMPENSATION:** This authorizes my physicians to furnish written reports and communicate orally with any representative, attorney for, or investigate from, my Worker's Compensation carrier ________________________ regarding my examination, diagnosis, treatment, and prognosis concerning injuries sustained as a result of an accident occurring on the _______________ day of ________________, 20_____.

IF PATIENT IS UNDER 18: I hereby give my permission for ____ to be treated by Santa Fe Imaging, LLC

PATIENT NAME

SIGNATURE / TELEPHONE VERIFICATION	WITNESS	DATE

ALL PATIENTS: THE FOLLOWING AUTHORIZATIONS MUST BE SIGNED INORDER TO EXPEDITE THE FILING OF YOUR INSURANCE CLAIM

PRINT PATIENT'S NAME	PATIENT OR GUARDIAN SIGNATURE	WITNESS	DATE

If patient is unable to sign explain here: ____

____ ____

WITNESS