



SAND LAKE IMAGING
— A Tradition of Trust —

DATE _____

PATIENT NAME _____

DOB _____ AGE _____ SEX _____ SS# _____

ADDRESS _____ CITY _____

STATE _____ ZIP _____ HOME TEL _____ CELL PHONE _____

WORK TEL _____ EMAIL _____

ASSIGNMENT OF BENEFITS: *I understand I am financially responsible for all charges whether or not paid by any insurance company.*

*I hereby authorize **Sand Lake Imaging L.L.L.P.** to release information as may be requested by my insurance company in order to secure payment. All medical benefits to which I am entitled, including Medicare, private insurance, and all other plans to: **Sand Lake Imaging L.L.L.P.***

This assignment will remain in effect until revoked by me in writing. A copy of this assignment is considered as valid as an original.

Sand Lake Imaging follows all guidelines set forth by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). A copy of the HIPAA Practice is available upon request.

Patient/Responsible party *Signature*

Date

