ALBANY ADVANCED IMAGING, PLLC
3 ATRIUM DRIVE
ALBANY, NEW YORK 12205

Name _____ Gender: ____ SS# _____

Address _____ City _____

State _____ Zip _____ Phone ( )_____

DOB _____ Marital Status: S M D W Email _____

Primary Care Physician: _____

Insurance Policy Holder Name (if not self) _____ DOB _____

Emergency Contact Information

Name _____ Relationship _____ Phone _____

Patient Insurance Waiver and Notice of Responsibility

As a consumer of medical service, you may have an agreement with an insurance carrier to assist with payment of your medical care. Albany Advanced Imaging, P.L.L.C., maintains agreements with various insurance carriers. Should we participate with your insurance carrier, we are happy to bill your insurance provider directly. Your signature on this form today authorizes us to do so. If your insurance carrier (for whatever reason) chooses not to satisfy your bill in full, you understand and accept complete personal responsibility for any payment due.

Some insurance companies require your doctor to obtain approval before imaging is performed. Albany Advanced Imaging, P.L.L.C. is not responsible for obtaining or justifying pre-certification, authorization or approval. Your signature authorizes Albany Advanced Imaging, P.L.L.C. to perform the examinations(s) requested by your doctor. Albany Advanced Imaging, P.L.L.C. is not responsible in any way should your insurance carrier deny payment for your examination.

Initial Here _____

Receipt of Notice of Privacy Practices ***POSTED ON WALL***

I have been informed of the Notice of Privacy Practices from Albany Advanced Imaging, P.L.L.C. concerning how the use of disclosure of Protected Health Information will be handled by the practice. This notice is posted in the office reception area. I understand I can also receive a copy of this notice.

Initial here _____

Signature: _____ Date: ____/____/____

Your relationship to the patient (if applicable) _____