



Decatur PET Imaging

Patient's Name _____
Last First M.I.

SS# _____ Date of Birth ____/____/____ Sex: M / F

Home Address _____ Apt# _____

City _____ State _____ Zip Code _____

Home # _____ Work # _____ Cell # _____

Name of emergency contact _____ Phone _____ Relationship _____
not living with you

Responsible party name _____
if patient is a minor Last First M.I.

Primary Insurance Information

Policyholder Name _____ Date of Birth ____/____/____ SS# _____

Insurance Name _____ Relationship to patient _____

Secondary Insurance Information

Policyholder Name _____ Date of Birth ____/____/____ SS# _____

Insurance Name _____ Relationship to patient _____

HIPAA Acknowledgment

I hereby acknowledge that I have been made aware that Decatur PET Imaging has a Privacy Policy in place accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). As a patient I acknowledge the following: Decatur PET Imaging has a privacy policy in effect and has made this policy available for review by placing a framed version of the policy in the waiting room. I am entitled to a copy of the Privacy Policy if I desire a copy for my personal file.

Upon your review of the above please sign at the bottom acknowledging that you have been advised of the privacy policy implemented by Decatur PET Imaging and have read and understand the form. If you desire a copy of the Privacy Policy please request one at this time.

- No, I do not wish to obtain a copy of the policy but I am aware one exists.
- Yes, I do want a copy of the HIPAA Privacy Policy. Policy was given to patient on _____ by _____
Date AHI Representative

I authorize the release of any previous results or images in the event AHI is in need of them to help with the diagnosis of my procedure today. I permit a copy of this authorization to be used in place of the original. I understand and acknowledge that I am personally responsible for the services rendered at this facility. American Health Imaging, Inc. will bill my insurance carrier as a courtesy. In the event of non-payment, I understand I will be responsible for any outstanding balances.

X _____
Patient signature or guardian for the minor patient Date