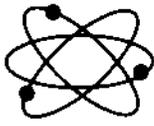


Date	PARTA
Account # (for office use only)	Patient Name (exactly as it reads on your insurance card)



**OUTPATIENT
RADIOLOGY CLINIC, P.A.
SCOTT FERGUSON, M.D.**

200 SOUTH RHODES, SUITE B
WEST MEMPHIS, ARKANSAS 72301
(870) 735-5555
(870) 735-5660 FAX

Initial Boxes

A copy of the HIPAA Notice of Privacy Practices has been made available to me.

I authorize the release of medical information necessary for the preparation of my insurance claims and consultation with my medical office. I authorize the insurance to make payment directly to the physician on any unpaid claim.

Although Outpatient Radiology Clinic will assist with filing any insurance or MEDICARE claims, I accept full responsibility for any unpaid balance. In the event of default, I agree to pay all cost of collection.

REQUEST FOR RELEASE OF MEDICAL RECORDS
We sometimes find it necessary to get your old films from another Dr.

I hereby authorize and request you to release my medical records to:
Outpatient Radiology Clinic, PA 200 South Rhodes, Ste. B
West Memphis, AR 72301

Mailing Address

City	State	Zip
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Home Phone	Cell Phone	email
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Place of Employment	Work Phone
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Patient's Social Security #

Date of Birth	Sex <input type="checkbox"/> M <input type="checkbox"/> F
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Primary Care Doctor

Other Doctor (needing report)

SCREENING MAMMOGRAM MEDICARE & INSURANCE PATIENTS REASON: More than one screening mammogram in 12 months.
If Medicare or insurance denies payment for the above reason, I agree to be personally responsible for payment.

Please give your INSURANCE CARDS to the person at the front desk to copy.

PART B (Insured Information)

Subscriber Name

Relationship to Patient (spouse, self, daughter, etc.)

Insured Social Security #	Insured Date of Birth
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If the patient is an adult, skip Part C.

PART C (If Patient is under 21)

Parent's Name

Parent's Date of Birth	Parent's Social Security #
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Patient Signature or Parent Signature for a Minor giving us the right to treat your child.
Have you had a mammogram in the last 12 months? Y N