INNOVACARE LLC
People. Technology. Results.

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PATIENT INFORMATION FORM

PLEASE PRINT

Name: _____Date of Birth: ____/_____/_____

Home Address: _____
(Street) (Apt)

_____
(City) (State) (Zip)

Home Phone: _____ **Cell Phone:** _____

Email Address:_____

Your Doctor's Information:

Doctor's Full Name	
Practice/Hospital Name	
Complete Address	
City, State & Zip Code	
Phone Number	

My medical insurance is with:_____

ID# or Cert# _____ Group # _____

I have secondary insurance (*please circle one)*: Yes or No If yes, Secondary insurance is with:

_____

ID# or Cert# _____ Group # _____

I acknowledge that I have reviewed the HIPAA Notice of Privacy Practices. _____ *(Initial here)*

I authorize the release of any medical information to process this claim. I authorize payment of medical benefits to Women's Diagnostic Center by Innovacare, LLC for medical services provided. I understand I am responsible for any balance not paid by my insurance carrier(s).

Signature: _____ **Date:** _____

I acknowledge that my refusal to sign this form or provide requested information will result in the inability of Women's Diagnostic Center by Innovacare, LLC to provide mammography services and I hold them harmless from any liability that occurs as the result of my refusing to comply with the policies of the organization. _____ *(Initial here)*

Signature: _____ **Date:** _____