Advanced Imaging Center

Patient Insurance Liability Form

ADVANCED IMAGING CENTER bills all insurance carriers as a courtesy. However, payment for all services rendered is ultimately the patient's responsibility.

We will make every attempt to collect payment from your insurance carrier prior to billing any of our patients. It is imperative that you provide the correct and current information for billing. Please indicate which carrier is primary and secondary. If today's visit is in any way related to some type of accident please indicate below exactly how your injury occurred.

Patient: _____

Primary carrier: _____ ID#: _____

Secondary carrier: _____ ID#: _____

Do you have *any* other coverage?

_____ Yes (if yes) Other Carrier: _____ ID#: _____
_____ No

Is today's visit accident related?
_____No _____Yes Date of injury: _____

If yes, please explain how accident occurred:
_____

Do you have an attorney involved? _____No _____Yes

Who was at fault to cause your injury(s)? Please check: _____myself _____other

Was the injury related to any of the following: **(please check only one)**
_____ Not Injury Related
_____ Automobile accident
_____ Employment
_____ Personal Injury (dog bite, slip and fall, personal attack, etc)
_____ Injured yourself with no fault of any other party

Signature: _____Date: _____

(Relationship if not the patient) _____