CASPERMEDICALIMAGING
Focused on Care, Driven by Excellence

Patient Information:

Patient's Full Legal Name: ____________________ Marital Status: ____________________
Mailing Address: ____________________ Spouses Name: ____________________
Physical Address: ____________________ Home Phone: ____________________
City: ____________________ Cell Phone: ____________________
State: ____________________ Patient's Date of Birth: ____________________
Zip: ____________________ Email Address: ____________________
SSN: ____________________ Sex: M F

If patient is a minor, parent's name or legal guardian:

Full Legal Name: ____________________ Marital Status: ____________________
Address: ____________________ Spouses Name: ____________________
City: ____________________ Home Phone: ____________________
State: ____________________ Date of Birth: ____________________
Zip: ____________________ Age: ____________________
SSN: ____________________ Sex: M F

Relative or Friend to Contact in the Event of an Emergency:

Name: ____________________ State: ____________________
Address: ____________________ Zip: ____________________
City: ____________________ Home Phone: ____________________
Relation: ____________________

Patient Employment Information:

Occupation: ____________________ State: ____________________
Employer: ____________________ Zip: ____________________
Employer Address: ____________________ Work Phone: ____________________
City: ____________________

Referral Information

Referring Doctor: ____________________
Reason for Exam: ____________________

Charles W. Bowkley III, M.D.
Eric W. Cubin, M.D., M.S.
Joseph C. McGinley, M.D., Ph.D.

419 S. Washington St., Suite 101
Casper, WY 82601

Michael L. Sloan, M.D.
Michael J. Flaherty, M.D.
Geoffrey G. Smith, M.D., F.A.C.R.
Daniel F. Sulser, M.D.

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If different from Above, the Insured Party is:

Primary Insurance Co: ________________________ ID/Plan #:___________________ Group #: __________________

Policy Holder: _________________________ Policy Holder Date of Birth: ______________

Address: _____________________________________ Zip: _________________

City: _________________________ Insurance Phone:_________________

Secondary Insurance Co: _________________________ ID/Plan #:____________________ Group #: _________________

Policy Holder: _________________________ Policy Holder Date of Birth: _______________

Address: ____________________________________ Zip: _________________

City: _________________________ Insurance Phone: _________________________

Are you currently covered by any of the following? (Check if appropriate)

Workman's Compensation: ______ Date of Injury:_____________ Case number:_____________
Indian Health: ______ Disability Determination: ______
Children's Health: ______ Medicaid/Title XIX: ______
Dept. of Vocational Rehab: ______ Medicare: ______

What date did your illness begin or injury occur? ___________

Is your condition related to employment? Y / N
Is your condition due to a motor vehicle accident? Y / N If yes, Date of the accident: ___________
Is this exam being done on an emergency basis? Y / N
Have you completed a patient financial Responsibility form? Y / N

I authorize the release of any medical information necessary to process my insurance claim(s).

I authorize and request that payment of all authorized insurance benefits, to include Medicare, non-Medicare and/or commercial insurance, be made on behalf of me to Casper Medical Imaging and/or Outpatient Radiology for any services furnished to me by this provider.

I understand that Casper Medical Imaging and Outpatient Radiology are related companies. I understand, and authorize, that any credits that may be applied to my account(s) are subject to transfer between the companies until my account(s) are paid in full.

I understand that should my insurance company not honor this assignment of benefits, I will immediately forward any payments received for services rendered by Casper Medical Imaging and/or Outpatient Radiology.

I agree, in the event I default on any portion of payment on my account, to pay additional collection costs. Interest or service fees and reasonable attorney fees as allowed by regulations and laws governing these transactions.

I agree that this authorization will cover all medical services rendered by Casper Medical Imaging and/or Outpatient Radiology until such authorization is revoked by me. A photocopy of this form may be used in lieu of the original.

I certify that the information provided above is true and correct to the best of my knowledge and I understand the financial policies pertaining to my account. I have read, understand, and agree to the statements on both sides of this form.

____ _____________________
Signature of Patient/Guarantor Date

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