GALAXY MRI
& DIAGNOSTIC CENTER
1110 N. GALLOWAY AVE, MESQUITE, TX 75149

Patient Information: **Referring Physician**:_____

Patient Name:_____DOB:_____SS#_____

Address:_____City_____State_____Zip:_____

Home#_____Work#_____Cell#_____

Driver's License#_____ State_____ Marital Status: M S D W

Insurance: (*Supply copies of all insurance policies effective & relevant to treatment being provided.*)
ATTENTION Medicare recipients: If you have an HMO/Replacement plan we need that information.
They are the rendering payer.
If this is *work related* you must provide us with that information prior to treatment!

Insurance:_____Grp#_____ID#_____

Card Holder:_____DOB:_____SS#_____

Secondary INS:_____Grp#_____ID#_____

Tertiary INS: _____Grp# _____ID#_____

Responsible Party:
Name:_____DOB:_____SS#_____

Address:_____City_____State_____Zip:_____

Emergency Contact:_____Phone#_____Relation:_____

Financial:
Thank you for choosing us as your healthcare provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our FINANCIAL POLICY, which we require you read and sign prior to your visit. All patients must complete and sign this form.
Galaxy MRI & Diagnostic Center participates in many insurance plans. **The only payments you will owe at the time of your visit are required co-payments, deductibles and non-covered charges**. **Any balance due after your insurance company makes payment is your responsibility**.
For All Patients: Please know your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Balance will be your own personal responsibility.
Minor Patients: The adult accompanying a minor and/or the patient (or guardian) of the minor is responsible for payment in full.

PATIENT PORTIONS ARE DUE IN FULL AT THE TIME OF SERVICE.
PAYMENT PLANS ARE ARRANGED UPON NECESSITY.
WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, OR AMERICAN EXPRESS.

*****In the event you issue a check and it is not honored and paid by you financial institution, you will be charged a **$35** return check fee and a $4 bank fee. ____**(initials)**

DELINQUENT ACCOUNTS:
Delinquent accounts are handled through an outside organization. In the event your account is turned over to a collection agency. You will be responsible for any collection fees and the full balance of your delinquent account. ____**(initials)**

WORKERS COMP: Is this work related Yes / No
In the event your claimed is denied or found non-compensable, you will be responsible for the balance. _____**(initials)**

I have read and understand the Financial Policy. I agree to abide by the above policy.

_____ _____
Signature of Patient / Responsible Party Date