

Date: ____/____/____
Date of Birth: ____/____/____
Patient Name: _____
Address: _____
City, State Zip _____

***Doctors Please Include a Diagnosis Code Here: _____

PERSONAL INJURY ATTORNEY/INSURANCE:

Med-Pay Carrier: _____ Phone #: _____
Carrier Address: _____ City, State Zip: _____
Policy #: _____ Claim #: _____ Med-Pay Amount: _____
Insured Name: _____ Insured SS# _____
Attorney Name: _____ Phone # _____ Fax # _____ email _____
Address _____ City, State Zip _____
Date of Injury: _____ Patients Phone Number: _____

GROUP/PRIVATE INSURANCE:

Insured Name: _____ Insured SS#: _____
Insured's Employer: _____ Employer Address: _____
Insurance Carrier: _____ Address: _____
Phone #: _____ Contact Person: _____
Group #: _____ Policy #: _____ ASH authorization #: _____

WORKERS' COMPENSATION INSURANCE: (We cannot bill ASH without this number)

W/C Carrier Name: _____ Phone # _____
Carrier Address: _____ City, State Zip: _____
Employer Name: _____ SS# _____ Phone # _____
Employer Address: _____ City, State Zip: _____
Date of Accident: _____ Claim #: _____ Adjuster: _____
W/C Authorization #: _____ (We cannot bill W/C without this number)

ASSIGNMENT OF BENEFITS

I hereby instruct the _____ Insurance Co. to pay by check made out to and mailed directly to: **Diagnostic Imaging 16200 E. Amber Valley Drive, Whittier, CA 90604**. If my current policy prohibits direct payment to doctor, then I hereby also instruct and direct you to make out the check to me and mail it as follows: **Diagnostic Imaging 16200 E. Amber Valley Drive, Whittier, CA 90604** for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. This is a **DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY**. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay in current manner any balance and/or Co-pay of said professional service charges over and above this insurance payment.

Date: _____ Signed: _____ (Patient or Insured)