Sound Choices, LLC

PLEASE PRINT CLEARLY

Patient Name_____ Age_____ Sex___ Marital Status_____
LAST FIRST MI

Address _____APT#_____ City_____ State_____ Zip_____

Home Phn _____ Work Phn_____ Cell_____

DOB_____ SSN_____ DL#_____ DL State_____

Referring Physician _____ Physicians Phone_____

For electronic correspondence, please provide your E-mail_____

WE DO NOT ACCEPT HUMANA HMOX, ANY FORM OF THE MEMORIAL HERMANN, OR ANY KELSEY SEYBOLD POLICIES!

Primary Insurance

Insurance Company_____ Claims Address_____

Insured Name_____ **Insured DOB**_____

Relationship to Insured: Self ☐ Spouse ☐ Child ☐

Insurance ID# / Subscriber #:_____

Account # / Group #_____

Secondary Insurance

Insurance Company_____ Claims Address_____

Insured Name_____ **Insured DOB**_____

Relationship to Insured: Self ☐ Spouse ☐ Child ☐

Insurance ID# / Subscriber #:_____

Account # / Group #_____

SELF PAY ☐ (please check here if you do not have insurance or maternity benefits)

4D ULTRASOUND ☐ GENDER CHECK ONLY ☐

Self pay, 4Ds and Gender Check payments are due in full at the time of service and there are **NO REFUNDS.**

NOTE: WHILE WE WILL GLADLY FILE YOUR CLAIM FOR YOU, PLEASE REMEMBER THAT YOU ARE PRIMARILY RESPONSIBLE FOR ALL CHARGES ON YOUR ACCOUNT NOT COVERED BY INSURANCE. YOU WILL RECEIVE A BILL FROM SOUND CHOICES, LLC FOR CHARGES NOT COVERED. ***ALL BALANCES ARE DUE BEFORE YOU SEE US FOR YOUR NEXT ULTRASOUND.***

OUR SERVICES ARE COMPLETELY SEPARATE FROM YOUR DOCTOR'S SERVICES.

Your images will be stored at the Sound Choices offices under lock and key. The information in your chart will only be discussed with your physician's office, your insurance company and the radiologist reading your films. Release of any information in your chart, other than as indicated above, will require a separate signed authorization from you, the patient.

I have read and understand the patient privacy policy for Sound Choices and authorize the release of medical records to physicians and/or insurance carriers. I authorize direct payment of all requested payable benefits from insurance and/or settlements to the provider.

**Patient Signature (Legal guardian if under 18):

X_____ Date_____

Should you have any questions, problems or concerns, please contact us at 281-485-2201.

FOR OFFICE USE ONLY

NOTES:

MR#_____

Diagnosis_____

Exam_____