Referring Physician:___________________ **Facility : Moody Diagnostic, Inc.**

Name: ____**Gender ( )M ( )F**

Address ____

City:____________________________ **State**___________ **Zip** ________________

Date of Birth _______________**E-mail** _____________________________________

Phone: ___________________________ **( )Home ( )Work ( ) Cell ( )Other**

Phone: ___________________________ **( )Home ( )Work ( ) Cell ( )Other**

GUARANTOR **( ) Same as Patient ( ) Relationship to Patient** _______________

Name: ________________________________ **Employer**_______________________

Address _______________________________ **Phone** __________________________

City State Zip __________________________ **Date of Birth**_____________________

EMERGENCY CONTACT____________________**Phone**_____________________

PRIMARY INSURANCE

Ins Company ______________________________**Group**________________________

I D or Policy #____

SECONDARY INSURANCE

Ins Company ______________________________**Group #** _____________________

ID or Policy #________________________________

I hereby assign, transfer and set over to Moody Diagnostics, Inc. all of my rights, title and interest to any medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by my insurance .

Signature of Patient or Responsible Party___________________________________

Date_____________