



PATIENT NAME: _____

Primary Insurance Name: _____ ID # _____

Claims Address: _____

Name of Insured If different than Patient _____ Date of Birth _____ Relationship _____

Group Number _____

Secondary Insurance Name: _____ ID# _____

Claims Address: _____

Name of Insured If different than Patient _____ Date of Birth _____ Relationship _____

Group Number _____

I authorize treatment of the patient named above. I hereby assign all the Medical Benefits to which I am entitled to Newport Imaging Center / Newport Center Radiology Associates. I understand that I am financially responsible for all incurred charges whether or not they are paid by Insurance. I hereby authorize the release of any information necessary to process this claim. I permit a photocopy of this authorization to act as the original.

AUTHORIZED SIGNATURE: _____ **DATE:** _____