MONTGOMERY RADIOGRAPHIC SERVICES
PLACENTIA SANTA ANA

PATIENT INFORMATION & CONSENT FORM

Patient_____ **DOB** _____ **Gender** _____
LAST FIRST M.I. M/D/Y M/F

Address _____
STREET CITY STATE ZIP

Home/Cell Phone _____**Work Phone** _____

Fathers Name (if patient a minor) _____

Address (if different) _____
STREET CITY STATE ZIP

Home/CellPhone _____**Work Phone**_____

Mothers Name (if patient a minor) _____

Address (if different) _____
STREET CITY STATE ZIP

Home/Cell Phone _____**Work Phone** _____

PLEASE READ CONSENT BEFORE SIGNING

1. Your signature authorizes Montgomery Radiographic Services to perform the imaging procedures prescribed by your dentist/physician on you or your minor child/dependent for whom you are legally responsible. You agree to accept full financial responsibility for the charges incurred today regardless of any personal insurance coverage. This includes deductibles, co-pays, co-insurance and items deemed by your insurance company as not covered or exceeding reasonable and customary charges. In the event of payment default, you agree to pay any and all costs associated in the legal collection of this debt.
2. Note that we **ARE NOT** authorized providers for either Medi-Cal or Medicare and cannot bill these entities on your behalf. You acknowledge that we have opted out of these programs and you cannot submit claims for our services to these agencies.
3. You consent to allow us to provide copies of your health records by staff delivery, USPS or transmitted via secure email to your referring doctor or with your permission, to any other doctors providing care for you or your minor child/dependent.
4. Additionally, you acknowledge that we make no explicit promises as to the timeliness of records received by your doctor.

Signature*

_____ **Date**_____
Adult patient, parent or guardian of minor child

Payees Valid Drivers License or **Alternate I.D**. (Required if paying by check)

_____ **Exp.**_____