

**AURORA DIAGNOSTIC IMAGING**  
**Patient Registration Form**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_

ASSIGNMENT OF INSURANCE BENEFITS Patients with insurances please read and sign. I hereby assign payment for all medical benefits including major medical benefits to which I am entitled from private insurance and any other health plans to: AURORA DIAGNOSTIC IMAGING, LLC. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered valid as an original. I understand I am financially responsible for all charges that are left unpaid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Signature \_\_\_\_\_ Date \_\_\_\_\_

PERMISSION FOR MEDICAL PROCEDURE By signing below I authorize Aurora Diagnostic Imaging to provide me with diagnostic imaging services as requested by my health care provider. I have read, understood and agreed that I am ultimately responsible for all professional and/or technical fees.

Signature \_\_\_\_\_ Date \_\_\_\_\_

RECEIVED BILLING POLICIES By signing below I agree that I have received a copy of the Billing Policies and understand that I am obligated to policies that fit my situation.

Signature \_\_\_\_\_ Date \_\_\_\_\_