



# AMERICAN HEALTH IMAGING, INC.

Patient's Name Plouk Robert A Sex M / F  
Last First M.I.  
Date of Birth 07/26/1968 Home/Cell # 2147997775 Work # \_\_\_\_\_  
Home Address 6827 Latta Pkwy Apt# \_\_\_\_\_  
City Dallas State TX Zip Code 75227  
E-mail Address: robplouk@gmail.com  
Emergency contact name Frank Abner Phone 2147997774 Relationship Partner

How did you hear about us? Doctor Insurance Co. Facebook Friend/Family \_\_\_\_\_  
(circle one) If a Friend/Family Member referred you, please tell us the person's name so we can thank them!

## Primary Insurance Information

Policyholder Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
Relationship to Policyholder: Self \_\_\_\_\_ Spouse \_\_\_\_\_ Child \_\_\_\_\_ Other \_\_\_\_\_

## Secondary Insurance Information

Policyholder Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
Relationship to Policyholder: Self \_\_\_\_\_ Spouse \_\_\_\_\_ Child \_\_\_\_\_ Other \_\_\_\_\_

## Work Comp and PIP Insurance Information

Employer Name: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Date of Injury: \_\_\_\_/\_\_\_\_/\_\_\_\_ State where injury occurred: \_\_\_\_\_  
Injury is: Work Related \_\_\_\_\_ Car Accident \_\_\_\_\_ Other (describe) \_\_\_\_\_

Responsible party name \_\_\_\_\_  
if patient is minor Last First M.I.

## HIPAA Acknowledgment

I herby acknowledge that I have been made aware that American Health Imaging has a Privacy Policy in place accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). As a patient I acknowledge the following: American Health Imaging has a privacy policy in effect and has made this policy available for review by placing a framed version of the policy in the waiting room. I am entitled to a copy of the Privacy Policy if I desire a copy for my personal file.

Upon your review of the above please sign at the bottom acknowledging that you have been advised of the privacy policy implemented by American Health Imaging and have read and understand the form. If you desire a copy of the Privacy Policy please request one at this time.

- ☐ No, I do not wish to obtain a copy of the policy but I am aware one exists.
- ☒ Yes, I do want a copy of the HIPAA Privacy Policy. Policy was given to patient on  
Date 05/17/2013 by \_\_\_\_\_  
AHI Representative

I authorize the release of any previous results or images in the event AHI is in need of them to help with the diagnosis of my procedure today. I permit a copy of this authorization to be used in place of the original. I understand and acknowledge that I am personally responsible for the services rendered at this facility. American Health Imaging, Inc. will bill my insurance carrier as a courtesy. In the event of non-payment, I understand I will be responsible for any outstanding balances.

X Robert Plouk 05/17/2013