



Community Based Imaging Excellence for Over 30 Years

Accredited by the American College of Radiology

NO FAULT / PERSONAL INJURY INFORMATION

Name (last) _____ (first) _____ (mi) _____
 Date of Birth _____ SS# _____ Sex (M/F) _____ Age _____
 Street Address _____
 City _____ State _____ Zip _____ Home Phone # _____
 Mailing Address (if different) _____
 City _____ State _____ Zip _____ Alternate Phone # _____
 Employer's Name _____
 Address _____ P.O. Box _____
 City _____ State _____ Zip _____ Work # _____ Ext _____
 Referring Physician _____ Date of Injury _____
 Copies of Report to (1) _____ (2) _____ (3) _____

AGREEMENT TO PAY MEDICAL COSTS IN THE EVENT OF FAILURE TO PROSECUTE OR IF COMPENSATION CLAIM IS DISALLOWED

Case #	Responsible Auto Insurance Carrier	Auto Insurance Phone #
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Primary Medical Insurance _____ ID # _____ Group # _____
 Employee/Subscriber's Name _____ Relationship _____
 Date of Birth _____ SS# _____ Sex (M/F) _____ Age _____
 Employer's Name _____ Phone # _____ Ext _____
 Secondary Medical Insurance _____ ID # _____ Group # _____
 Employee/Subscriber's Name _____ Relationship _____
 Date of Birth _____ SS# _____ Sex (M/F) _____ Age _____
 Employer's Name _____ Phone # _____ Ext _____

In the event that the auto insurance carrier does not cover my charges, I, _____ hereby agree to pay Housatonic Valley Radiological Associates, PC, or its affiliates usual and customary fees for services rendered to the above named claimant in the above identified case. I understand I will be responsible for any and all charges I will have incurred in seeking services at this office. I also understand that if my medical insurance requires referrals and/or pre-certifications needed for tests, and I have a test done without obtaining all that is required, I agree to be responsible for the payment to HVRA and its entities, which perform the test(s) if my auto insurance does not pay.

Signature _____ Date _____