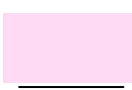


**CLIENT INFORMATION - EVALUATION**

Victorious Images 7191 Richmond Road, Suite E Williamsburg, VA 23188.7239

NAME	DOB	SSN - LAST 4	
ADDRESS	CITY	ST	ZIP + 4
HOME PHONE	CELL PHONE	WORK PHONE	E EMPLOYER
INSURANCE NAME	SUBSCRIBER'S NAME	DOB	RELATION TO CLIENT
SECONDARY INSURANCE	SUBSCRIBER'S NAME	DOB	SSN - LAST 4 RELATION TO CLIENT
<b>Email:</b>			

**HIPPA/Supplier Standards and Medicare Supplier Standards Acknowledgement**

 I hereby acknowledge that I have been provided INFORMATION on where to locate  
 Victorious Images' Notice of Privacy Practices and/or the Medicare Supplier Standards.  
 \_\_\_\_\_  
 Initials (www.victoriousimages.com)

**AUTHORIZATION TO DISCLOSE AND RECEIVE CLIENT HEALTH CARE INFORMATION**

I hereby **AUTHORIZE** Victorious Images to release any clinical records needed to the insurance carrier (s) listed above, to my referring doctor (s),

Dr.(s)/NP \_\_\_\_\_

and to those listed below.

\_\_\_\_\_  
\_\_\_\_\_

Victorious Images may **RECEIVE** medical records from the same or any other medical/professional establishment they deem necessary for the purpose of filing my insurance claims.

It is my understanding this authorization will remain in effect until I cancel by written notice.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date