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 MPLOYER	
INSURANCE NAME	SUBSCRIBER'S NAME		DOB	RELATION TO CLIENT
SECONDARY INSURANCE	SUBSCRIBER'S NAME	DOB	SSN - LAST 4	RELATION TO CLIENT
Email:				

HIPPA/Supplier Standards and Medicare Supplier Standards Acknowledgement

_____
Initials

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. (www.victoriousimages.com)

AUTHORIZATION TO DISCLOSE AND RECEIVE CLIENT HEALTH CARE INFOMATION

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