

HAVE YOU BEEN HERE TO ANY OF OUR OFFICES BEFORE? YES / NO

IF YES WHERE? _____

LAST NAME: _____ FIRST NAME: _____

ADDRESS: _____

APT# _____ CITY _____ STATE: _____ ZIP _____

HOME PHONE() _____ BUSINESS PHONE() _____

SS # _____ DATE OF BIRTH _____ SEX F M

REFERRING PHYSICIAN NAME: _____ PHONE () _____

ADDRESS _____ FAX() _____

OTHER THAN YOUR REFERRING DOCTOR, NAME OF ANOTHER MD WHOM YOU WISH TO GET RESULTS:

NAME: _____ PHONE () _____ FAX () _____

PCP NAME: _____ PHONE () _____ FAX () _____

NAME OF EMPLOYER _____ PHONE() _____

EMPLOYER'S ADDRESS _____

INSURANCE INFORMATION

COMMERCIAL / PRIVATE

NAME OF INSURANCE CARRIER: _____

POLICY #: _____ GROUP #: _____

RELATIONSHIP TO POLICYHOLDER: SELF SPOUSE CHILD OTHER

SECONDARY INSURANCE NAME _____ ID# _____

IN CONSIDERATION OF THE SERVICES RENDERED, I HEREBY ASSIGN MY RIGHTS UNDER HEALTH CARE COVERAGE TO THE EXTENT OF THIS BILL. PLEASE PAY DIRECTLY TO ALL COUNTY OPEN MRI & DIAGNOSTICS RADIOLOGY FOR MEDICAL SERVICES PROVIDED TO ME. I FURTHER UNDERSTAND THAT IF SAID SUM IS NOT COLLECTED I WILL REMAIN PERSONALLY RESPONSIBLE FOR THE BALANCE DUE.

DATE: _____

SIGNATURE: _____

MEDICAL RELEASE

This is to advise ALL County Open MRI & Diagnostics Radiology to release to my physician, Attorney and Insurance Company a full report or films containing my diagnosis, treatment, etc. upon their request.

Date: _____

Signature: _____
(Patient or parent of minor patient)

PREGNANCY CONSENT FORM

I have been advised to have an x-ray(s) by my physician Dr. _____
I understand that you do not routinely perform x-ray(s) examination on pregnant patients. I am totally aware of the remote possibility of injury to my fetus or myself, but I chose to accept that responsibility.

Date: _____

Signature: _____
(Patient or parent of minor patient)

PLEASE CIRCLE ONE OF THE FOLLOWING:

1. I AM PREGNANT
2. I AM NOT PREGNANT
3. I DO NOT KNOW IF I AM PREGNANT

ASSIGNMENT OF INSURANCE BENEFITS

I the undersigned hereby grant permission for the above referenced provider to contact my insurance carrier to determine benefits and assign all available medical and/or surgical benefits, to include major medical benefits, private insurance and any other health plans to which I am entitled to the health provider and/or practice listed above. This assignment will remain in effect until revoked by me in writing.

I authorize a photocopy or facsimile of this assignment to be considered to be as valid as an original. I understand that I am financially responsible for all charges in the event that it is determine that I was not a covered person by said insurance.

I hereby authorize said assignee to release all information necessary to secure the payment.

(Patient or parent of minor patient)

Date

MODIFICATION OF ASSIGNMENT

With respect to the assignment of Personal Injury Protection benefits by

_____, **to All County Open MRI.**

(injured person)

I, All County Open Mri & Diagnostics Radiology do hereby certify that I have not received any payment from or on behalf of the above named injured person, nor do I intend to pursue payment directly from such person in the future, for the services provided on behalf of said named person for the period for injuries sustained due to a motor vehicle accident which occurred on _____, not withstanding

(date of accident)

any prior written agreement to the contrary.

**This agreement shall become null and void if at anytime it is determined that benefits are not payable due to the following circumstances: lack of coverage, violation of a policy condition, or determination that the treatments/services rendered are not related to said motor vehicle accident. I further certify that a copy of this affidavit has been forwarded to _____
_____ at his/ her last known address. **(injured person)****

cc: Patients' name and address

I state under penalties of per jury, that statements herein made are true, except as to such statements as are based on information and belief, which statements I believe to be true.

(Signature of Provider)

(Date)