

HAVE YOU BEEN 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: () _____

OCCUPATION: _____

NAME OF EMPLOYER: _____ PHONE: () _____

EMPLOYER'S ADDRESS: _____

City State Zip

INSURANCE INFORMATION

WORKERS COMPENSATION

NAME OF INSURANCE CARRIER: _____

WCB #: _____ CARRIER CASE #: _____

HAS THIS ACCIDENT BEEN REPORTED TO YOUR EMPLOYER: YES NO

DATE OF INJURY: _____

NO FAULT

NAME OF INSURANCE CARRIER: _____

CLAIM #: _____ POLICY NAME / NUMBER: _____

RELATIONSHIP TO POLICYHOLDER: SELF SPOUSE CHILD OTHER

DATE OF ACCIDENT: _____

TO OUR PATIENTS:

PLEASE PROVIDE ANY ADDITIONAL INSURANCE INFORMATION APPLICABLE TO YOUR TEST INCLUDING MEDICARE, MEDICAID OR PRIVATE IN ORDER THAT WE MAY BETTER SERVE YOU.

NAME OF INSURANCE CARRIER: _____

ID #: _____ GROUP #: _____

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

(Patient or parent of minor patient)

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

_____, 2 _____

_____(Attorney)

Re: (Patient) _____

(Date of Service) _____

I hereby direct and authorize you to pay to All County Open MRI & Diagnostics Radiology out of any monies that may become payable to me or my agent from you as my attorney, indemnitor or other capacity, from any settlement, judgment or otherwise of my claim for personal injuries or other damages sustained by me in an accident, or from any contract of insurance or from any estate of which I am beneficiary, the fee now due or which may become due to All County Open MRI from me for professional medical services rendered by it, which sum or sums I hereby assign, transfer and set over unto it. There are to be no reductions of any nature and no proration of any fees. No assignment is intended of my claim or part thereof, but only a portion of the proceeds to the extent herein provided, as if said proceeds were presently a liquidated amount. If the person treated be an infant, this agreement shall apply to my share of liability as parent and/or guardian.

This arrangement is made voluntarily by me because of my present inability to pay the aforesaid fees and as security for my indebtedness, which nevertheless, is specifically not contingent upon my recovery of damages except at the option of All County Open MRI.

I expressly direct you not to pay to me or anyone on my behalf any monies on account of my aforesaid claim until you have paid to All County Open MRI the entire amount due it without further notice, and I authorize said All County Open MRI to collect the assigned sum. I agree to hold you harmless from any liability for and release you from any claim on account of any payments made in compliance with the directions herein. Any adjustment or payment of my claim or cause of action is understood to include and be subject to the terms of this agreement and any release signed by me or satisfaction of judgment given shall not be valid or effective unless and until payment to All County Open MRI has been made of all of its aforesaid fees with ten (10) days after receipt by you of the check or checks by way settlement or judgment. This agreement is to be effective and binding irrespective of the amount of any settlement or judgment.

Dated this _____ day of, _____, 2 _____

(Patient or parent of minor patient)

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.

(Date)

(Signature of Provider)