MIDDLETOWN
MEDICAL IMAGING

Chart #_____ APPT BY: _____

Patient Name_____ DOB_____

Address_____ APT# _____ City_____ Zip _____

Phone #_____ SS#_____ Email: (appointment alerts)_____

Work status ☐ FT ☐ PT ☐ Unemployed ☐ Retired ☐Student
Marital status ☐ Single ☐ Married ☐ Widowed ☐ Divorced
How were you referred to our office ☐ Referring Dr ☐ Internet ☐ Zoc Doc ☐ Returning Patient ☐ ETC._____

Employer_____ Employer's Address _____

Emergency contact person _____phone #_____

INSURANCE INFORMATION

Is this related to an accident	☐ Yes ☐No ☐ NA If yes, ☐ Auto, ☐ W.Comp. ☐ Other
Date of accident : _____	State Auto Injury occurred in: _____

Attorney Name: _____	Phone#_____
Are you treating with a Chiropractor ☐ Yes ☐ No	Name: _____Phone: _____

PRIMARY **Authorization #** _____

Name Insurance: _____	Id # _____	Group # _____
Phone # _____	Insurance Address _____	Adj Info _____
Subscriber name _____	D.O.B/ S.S.# _____	Relationship _____

SECONDARY **Authorization #** _____

Name Insurance: _____	Id # _____	Group # _____
Phone # _____	Insurance Address _____	Adj Info _____
Subscriber name _____	D.O.B/ S.S.# _____	Relationship _____

I hereby authorize this medical facility and its representatives to release any information acquired in the course of my examination or treatment to the Social Security Administration, its intermediaries or carriers (for Medicare patients) and all other third-party insurance carriers needed for the processing of insurance claims. I permit a copy of this authorization to be used in place of the original.

I hereby assign all medical benefits; to include major medical benefits to which I am entitled including Medicare, private insurance, and any other health plans to this facility. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by insurance. I further understand if my account is sent to collection for payment, I will incur additional charges (a minimum of 25%) on the amount sent; this applies to copayments as well. This is for today's service and any future services at North Dover Radiology. I hereby authorize said assignee to release all information necessary to secure the payment of said benefits.

This facility will provide a locker in which you must store your personal items and valuables. Please lock these items in the area provided, and bring the key with you into the scan room for security. North Dover Radiology will not accept liability for any personal belongings.

I hereby authorize North Dover Radiology to deliver my imaging studies to the referring physician or specialist at his/her request. I understand that these studies are a permanent part of my medical record. I hereby release North Dover Radiology from any and all legal responsibility or liability that may arise from release of these films. I have been offered a copy of the HIPPA compliance and understand and agree to its terms.

_____ _____

Signature **Today's date**

All patients/legal guardians must <u>REVIEW, SIGN and DATE</u> all paperwork.