

Jefferson Imaging-Doylestown MRI
Patient Demographics

First Name: _____ Last Name: _____ M.I.: _____

Date of Birth: _____ Social Security No.: _____ Sex: M/ F

Height: _____ Weight: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: () _____ Work/Cell Phone: () _____

Referring Doctor: _____

Referring Doctor Phone: () _____ Fax: () _____

INSURANCE INFORMATION (PRIMARY)	INSURANCE INFORMATION (SECONDARY)
Insurance Co. Name _____	Insurance Co. Name _____
Phone: _____	Phone: _____
ID #: _____	ID #: _____
Group #: _____	Group #: _____
Auto (Y/N) _____ Workers Comp (Y/N) _____	Subscriber: _____
Date of Accident/ Injury: _____	
Subscriber: _____	
Employer: _____	

COMMERCIAL/WORKER'S COMP/AUTO INSURANCE

I hereby authorize release of information necessary to file a claim with my insurance company, employer or benefit plan administrator and assign benefits otherwise payable to me to Jefferson Imaging-Doylestown MRI. I understand that I am financially responsible for any balance not covered by this assignment. A copy of this signature is as valid as the original.

Signature _____ Date _____

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made on my behalf for any services furnished to me by Jefferson Imaging-Doylestown MRI. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents, any information needed to determine these benefits for related services.

Signature _____ Date _____

NOTICE OF PRIVACY POLICY

Jefferson Imaging-Doylestown MRI considers non-public personal information (NPI) confidential and has policies and procedures in place to protect it against unlawful use and disclosure. When necessary or appropriate for your care or treatment, or other related activities, we use NPI internally, and disclose it to healthcare providers (doctors, pharmacies, hospitals, and other caregivers), payors (healthcare provider organizations and others who may be responsible for payment for the services or benefits you receive under your plan), third party administrators, government authorities and their respective agents. These parties are required to keep NPI confidential as provided by applicable law, and any other use and/or disclosure than described herein will be made only upon the patient's written authorization and patient may revoke at any time.

If you wish to release information to any party other than the afore mentioned, please request an Authorization to Release Patient Health Information.

For more information concerning your protected health information, please request a copy of our comprehensive privacy policy.

I, the undersigned, have read, understand, and acknowledge having received the above Notice of Privacy Policy.

Signature: _____ Date: _____