CLEARVIEW
OPEN MRI

Patient Registration Form

Patient ID#: _____

Patient Name			
Date of Birth	Social Security Number	Patient Sex	Marital Status
Present Address (Address, City, Zip Code)			
Patient Phone Number	Cell phone Number	Email Address	
Guardian/Emergency Contact	Phone Number	Relationship	
Ordering Physician Name		Phone Number	
Is your study today related to: (circle one) Worker's Compensation Auto Accident Slip and Fall Other (Explain) _____ Date of the Injury/ Accident: _____			
Attorney Name	Attorney's Phone Number		
Employer Name		Phone Number	
Primary Insurance Company	Insurance ID #	Group #	
Name of Insured		Insured Date of Birth	
Secondary Insurance Company	Insurance ID #	Group #	
Name of Insured		Insured Date of Birth	

I understand that services rendered by Clearview Open MRI and its physicians are necessary for the patient. I hereby consent to authorize the X-RAY and/or MRI study ordered by my physician. I authorize Clearview Open MRI to obtain or secure any medical records necessary. To the best of my knowledge, the above information is true and correct.

Patient/Guardian Signature: _____ **Date:** _____

Patient/Guardian Name (Please print): _____

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PATIENT ID: _____ REFERRING PHYSICIAN: _____

PATIENT'S NAME: _____

GENDER: M ☐ F ☐ HEIGHT: _____ WEIGHT _____ DATE OF BIRTH _____

IS YOUR ACCIDENT DUE TO AN AUTO ACCIDENT Y ☐ N ☐ SLIP & FALL Y ☐ N ☐ OTHER ☐

DATE OF ACCIDENT: _____

PLEASE DESCRIBE YOUR SYMPTOMS:

_____

PLEASE LIST ALL SURGERIES:

_____

CAUTION

Magnetic resonance imaging (MRI) systems use strong magnetic fields and radio-frequency energy for imaging soft tissue in the body. Certain implants, devices, or objects may pose a hazard to individuals in close proximity to the magnet of the MRI system and/or may interfere with the MRI procedure.

PLEASE INDICATE IF YOU CURRENTLY HAVE ANY OF THE FOLLOWING:

Aneurysm clip(s)	Yes	No	Radiation seeds or implants	Yes	No
Cardiac pacemaker	Yes	No	Swan-Ganz or thermodilution catheter	Yes	No
Implanted cardioverter defibrillator (ICD)	Yes	No	Medical patch (transdermal)		
Electronic implant or device	Yes	No	(e.g., Nicotine, Nitroglycerine)	Yes	No
Magnetically activated implant or device	Yes	No	Any metallic fragment in eyes	Yes	No
Neurostimulator	Yes	No	Bullets	Yes	No
Spinal cord stimulator	Yes	No	Tissue expander (e.g., breast)	Yes	No
Bone growth/bone fusion stimulator	Yes	No	Surgical staples, clips, or metallic sutures	Yes	No
Internal electrodes or wires	Yes	No	Joint replacement (hip, knee, etc.)	Yes	No
Cochlear, otologic, or other ear implant			Bone/joint pin, screw, nail, wire, plate, etc.	Yes	No
(including hearing aid/stapes)	Yes	No	Intrauterine device (IUD), diaphragm,		
Insulin or other infusion pump	Yes	No	or pessary	Yes	No
Implanted drug infusion device	Yes	No	Braces, denture, or partial plates	Yes	No
Any type of prosthesis (e.g., eye penile)	Yes	No	Tattoo or permanent makeup	Yes	No
Heart valve prosthesis	Yes	No	Body piercing jewelry	Yes	No
Blood clot filter	Yes	No	Wig	Yes	No
Eyelid spring or wire	Yes	No	Claustrophobia	Yes	No
Artificial or prosthesis limb	Yes	No	Pregnant	Yes	No
Metallic stent, filter, or coil	Yes	No			
Shunt (spinal or intravemtricular)	Yes	No			
Vascular access port amd/or catheter					
(e.g., Broviac, Port-A-Cath, Hickman	Yes	No			

****** PLEASE REMOVE ALL HEARING AIDS AND ALL JEWELRY ******

I hereby certify that the above questions have been answered truthfully and to the best of my ability and that I hold Clearview Imaging harmless thereof.

_____ _____

Patient/ Guardian Signature Date

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Patient ID: _____ **Patient's Name:** _____

PATIENT ACKNOWLEDGEMENT FORM

Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice
- The Practice reserves the right to change the Notice of Privacy Policies
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at an> time and all future disclosures will then cease
- The Practice may condition treatment upon the execution of this Consent.

Patient Name (print): _____

Patient Signature: _____
Patient or Legal Representative

Relationship to Patient (if other than patient): _____

Date: _____/_____/_____

Witness Signature: _____
Practice Representative

Date: _____/_____/_____

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Patient's Name: _____

ASSIGNMENT, LIEN AND AUTHORIZATION

I hereby authorize you. my insurance company and/or my attorney, to pay directly to Clearview Open MRI. ("Assignees") such sums as may be due and owing Assignees for services rendered. I also authorize my insurance company to disclose coverage information to Clearview Open MRI, and to withhold such sums for any disability benefits, medical payments. No Fault benefits, or any other insurance benefits obligated to reimburse or from any settlement, judgment, or verdict on my behalf as may be necessary to adequately protect said Assignees. I hereby further give a lien to said Assignees any and all insurance benefits named herein and any and all proceeds of any settlement, judgment, or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by Assignees.

Pursuant to Florida Statutes 627.736(5) 1 hereby assign the benefits of insurance and any and all causes of action available under my policy *oi* automobile insurance. In the event my insurance company, obligated to make payments to me upon charges made by Assignees for services, refuses to make or reduces such payments, in order to maximize the benefits available under my policy coverage. 1 request that: the company, assuming there is coverage remaining at the time the company receives the Assignees bill, and if the company fails to pa) Assignees the lull amount of the bill(s) submitted, to avoid exhaustion of coverage while Assignees pursues its rights under this Assignment. **I authorize and direct the Insurance Company to set aside and place in escrow an amount equal to the full amount of any such denial or reduction, and to hold that amount in escrow until the dispute is resolved in the appropriate forum.**

I understand that I remain personally responsible for the total amounts due Assignees for their services. I further understand and agree that this Assignment. Lien and Authorization does not constitute any consideration for Assignees to await payments and they may demand payments from me immediately upon rendering services at their option.

I authorize Assignees to release any information pertinent to my case to any insurance company, adjuster, or attorney to facilitate collection under this Assignment Lien and Authorization. I agree that the above mentioned Assignees be given Special Power of Attorney to endorse/sign my name on any and all checks and claim forms for payment of my bill.

I understand that if this account is assigned to any attorney for collection and/or suit, the Assignees shall be entitled to reasonable attorney's fees and cost of collection. I also understand that if any bad check is written. I agree to pay for those added costs.

Dated this _____day of_____ 20_____

_____ _____

Signature of Policy holder/Claimant **Witness**