



Patient Registration Form

CLEARVIEW
OPEN MRI

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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REFERRING DOCTOR _____ ACCOUNT NUMBER: _____

PATIENT'S NAME: _____

IS THERE ANY POSSIBILITY OF PREGNANCY? YES OR NO

IS YOUR INJURY DUE TO AN ACCIDENT? YES OR NO

AUTO ACCIDENT

WORKER'S COM

SLIP AND FALL

OTHER _____

DATE OF ACCIDENT: _____

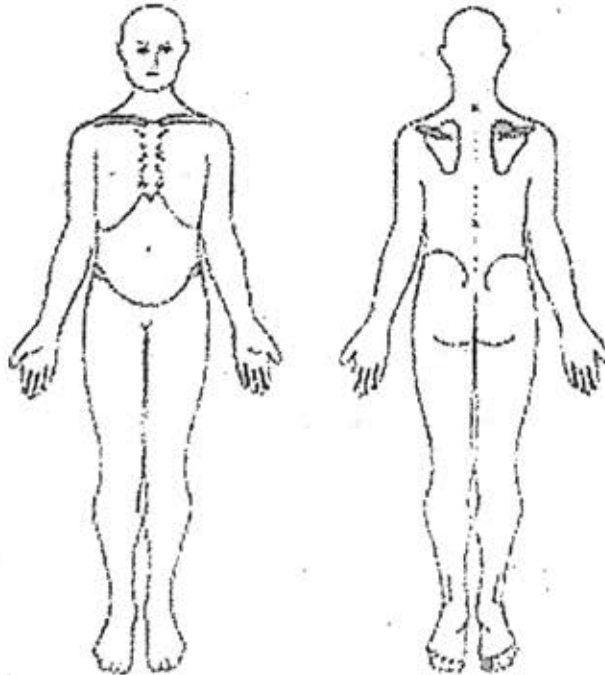
PLEASE DESCRIBE YOUR SYMPTOMS- ie: PAIN / NUMBNESS / BURNING / TINGLING

SIGNATURE OF PATIENT/ GUARDIAN

DATE

USING THE SYMBOLS BELOW, PLEASE INDICATE ON THE DIAGRAMS WHERE YOU ARE EXPERIENCING THESE SYMPTOMS.

- XXXX = PAIN
- 0000 = NUMBNESS
- //// = ACHING
- **** = PINS/ NEEDLES



TECH NOTES:



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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 any 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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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) I hereby assign the benefits of insurance and any and all causes of action available under my policy of 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. I request that: the company, assuming there is coverage remaining at the time the company receives the Assignees bill, and if the company fails to pay Assignees the full 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