ADVANCED DIAGNOSTIC IMAGING OF NJ

34 Route 17 North, Paramus NJ 07652 Tel. (201) 368 – 2005 Fax (201) 368 – 1431

PATIENT INTAKE FORM

DATE:_____

PATIENT'S NAME _____
(FIRST) (LAST)

ADDRESS_____
(STREET)

_____
(CITY) (STATE) (ZIP CODE)

HOME PHONE # _____ CELL# _____

DATE OF BIRTH: _____/_____/_____ **SS#** _____-_____-_____ MALE_____ FEMALE_____

MARITAL STATUS: M ___S __W ___D___ **ARE YOU PREGNANT?** (Please circle) **YES** **NO**

EMERGENCY CONTACT:_____ PHONE # _____
(NAME)

REFERRING PHYS: _____ PHONE # _____
(NAME)

INSURANCE INFORMATION

MEDICAL INS. CARRIER_____
(ADDRESS)
POLICY_____GROUP#_____ CLAIM #:_____

PHONE # _____

INSURED: _____
(NAME) (ADDRESS IF DIFFERENT FROM ABOVE)

DATE OF BIRTH: ___/___/____ SS # _____ SPOUSE_____ PARENT_____ OTHER_____

CONSENT TO PROVIDE TESTING AND TO RELEASE INFORMATION

I hereby authorize Open MRI ADI of NJ and its associates to provide testing and/or examination. The nature and purpose of the tests and /or the examination has been explained to me and I have been given the opportunity to ask questions. I acknowledge that no guarantee has been made as to the results to be obtained.

In the event of accidental exposure to my body fluids, I further consent to the drawing of blood and testing for syphilis, the hepatitis B and human immunodeficiency viruses if any individual at Advance Diagnostic Imaging is exposed. The results of these tests will remain strictly confidential except as specified by law. Any information pertinent to my case in the course of my examination or testing may be released to my physician, insurance company, adjuster, or attorney if applicable in this case.

_____ _____

SIGNATURE of PATIENT/GUARDIAN **DATE**

PATIENT QUESTIONARY/ PREGUNTAS A CONTESTAR

Please answer all questions. Do not hesitate to speak with our office staff with any questions
Por favor conteste todas las preguntas. Si tiene alguna inquietud no se resista en hablar con nuestros colaboradores.
Name/ *Nombre*_____Date of Birth/*Fecha de Nacimiento*_____

1. - Please indicate the symptoms you are having for the today's examination. Please check:
Favor marcar los sintomas que usted esta teniendo a este momento antes de ser examinado:

_____Headache/*Dolor de Cabeza*	_____Knee(Right/Left)/ *Rodilla (Derec/Izquie)*
_____Vission Loss*/Perdida de Vision*	_____Lower back pain/*Dolor de espalda baja*
_____Dizziness/ *Mareos*	_____Upper back pain/ *Dolor de espalda alta*
_____Numbness/*Temblores*	_____Neck pain/*Dolor de cuello*
_____Ringing in ears/*Zumbido en oidos*	_____Abdominal pain/*Dolor abdominal*
_____Arm (Right/Left)/*Brazos(Derec/Izquie)*	_____Foot(Right/Left)/Pies(*Derecho/Izquierdo)*
_____Leg(Right/Left)/*Piernas(Derec/Izquie)*	_____Shoulder(Right/Left)/*Hombros(Derec/Izquie)*

2.-How long have you had above symptoms?_____
*Hace cuanto tiempo tiene los sintomas mencionados arriba?*_____

3.-Is this result of any injury and/or accident? Yes No If yes, please describe it_____
*Es este el resultado de alguna caida, golpe o accidente Si No Si dijo que si, por favor describala:*_____

4.-Have you had prior imaging studies of the body part being examined today?Yes No
Ha tenido algun studio magnetico anteriormente de la parte de su cuerpo a ser examinada hoy? Si No

5.-Have you had or do you have cancer now? Yes No
Ha padecido o padece de cancer ? *Si* *No*

6.-Do you have any kidney disease? Yes No
Padece de alguna enfermedad renal? *Si* *No*

7. Women: Is there any chance that you are pregnant? Yes No
Mujeres: Hay alguna posibilidad de embarazo? *Si* *No*

8.Women: Are you breast feeding? Yes No
Mujeres: Esta dando el pecho? *Si* *No*

SURGICAL HISTORY
SPINAL SURGERY (specify what disc) _____ Date: _____
ORTHOPEDIC SURGERY (in the area to be studied) _____ Date: _____
WHAT HOSPITAL/SURGEON _____

WEIGHT: _____ **ALLERGIES: _____**

_____ _____
PATIENT SIGNATURE WITNESS SIGNATURE

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ASSIGNMENT OF BENEFITS

PATIENT'S NAME:_____

I **irrevocably** assign to Advanced Diagnostic Imaging Of New Jersey , Inc., my medical provider, all my rights and benefits under my insurance contract for payments services rendered to me, I authorize all information regarding my benefits under any insurance policy relating to any claims by Advanced Diagnostic Imaging of New Jersey, Inc. to be released to Advanced Diagnostic Imaging of New Jersey, Inc.

I irrevocably authorize Advanced Diagnostic Imaging of New Jersey, Inc. to file Insurance claims on my behalf for services rendered to me as a result of this automobile accident and this specifically includes filing arbitration/litigation in your name on my behalf against the PIP/health care carrier. I irrevocably direct that all such payments go directly to Advanced Diagnostic Imaging of New Jersey , Inc., my medical provider.

I irrevocably authorize Advanced Diagnostic Imaging of New Jersey, Inc. to act on my behalf . I **consent** to your acting on my behalf in this regard and in regard to my general health insurance coverage pursuant to the benefit denial process set forth in the NJ Administrative Code and report any suspected violations of proper claims practices to the proper regulatory authorities.

In the event the insurance carrier responsible for making medical payments in this matter does not accept my assignment, or my assignment is deemed invalid, I execute this **limited power of attorney** and appoint your collection attorney as my agent to collect payment for your medical services directly against the carrier in this case including filing an arbitration demand or lawsuit. I specifically authorize that attorney to file directly against that carrier in my name or in your name as a medical provider rendering services to me.

This assignment of benefits has been explained to my full satisfaction and I understand its nature and effect.

I do hereby authorize the above facility to furnish you, my attorney/insurance carrier, with a full report of my examination and diagnosis of myself in regard to my accident/illness which occurred/began on_____

FINANCIAL AGREEMENT

I, _____, hereby agree to the following, as a condition of receiving treatment at ADI

ADI, as a courtesy to its patients, participates with certain insurance companies and managed health care programs. If I am a member of one of these plans, ADI will submit an insurance claim on my behalf.

Any medical services which are not covered by my insurance (including denials of payments based upon incorrect, misleading, or incomplete information provided by me) are my responsibility, and payment in full will be due and payable by me upon receipt of a billing statement.

If my insurance covers only a portion of ADI's charges for medical services, and/or pays ADI less than its full charges, I am responsible for the difference between ADI's customary fee and any partial or incomplete payments made by my insurance company. Payment in full will be due and payable by me upon receipt of a billing statement.

In addition, if I provide to ADI incorrect, misleading, or incomplete information which results in an insurance company, government agency or other entity conducting an audit, investigation, litigation, recoupment effort, arbitration or other proceeding against ADI or relating to ADI's charges and/or services, I agree to take full personal responsibility for my actions, and I agree to indemnify and hold ADI harmless, including, without limitation, reimbursing ADI for all damages, penalties, costs and expenses (including attorneys' fee) Incurred by or assessed against ADI in all such matters.

PATIENT'S SIGNATURE: _____ **DATE:** _____/_____/_____

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Patient Name: _____

ADVANCED DIRECTIVE – LIVING WILL AND DO NOT RESUSCITATE

Due to the ambulatory nature of your testing and this facility, we will **NOT HONOR Do not Resuscitate or Advanced Directive** orders for the short time you are here as a patient. In signing this form you have agreed to the postponement of you directives until you leave this facility. Information on Advanced Directives/Living Wills is available upon request.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices. I understand that I have the right to refuse to sign this acknowledgement if I so choose.

_____ _____

Signature of Patient or Legal Representative **Date**

_____

Print name of Patient's Representative (if applicable)

Relationship to Patient (if applicable)

_____ Parent or guardian of unemancipated minor
_____ Court appointed guardian
_____ Executor or administrator of decedent's estate
_____ Power of Attorney

****

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices on the following date _____ but acknowledgment could not be obtained because:

_____ Patient /representative refused to sign

_____ Emergency situation prevented us from obtaining acknowledgement at this time (will attempt again at a later date)

_____ Communication barriers prohibited obtaining acknowledgement (Explain)

SIGNATURE OF THE PATIENT (OR AUTHORIZED PERSON) **DATE**

RELATIONSHIP TO PATIENT DATE

SIGNATURE OF WITNESS DATE

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RECORDS RELEASE FORM

_____

DOCTOR'S OFFICE OR HOSPITAL

_____

ADDRESS

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE TO:

ADVANCED DIAGNOSTIC IMAGING of NJ 34 ROUTE 17 N. PARAMUS NJ 07652

COMPLETE MEDICAL RECORDS IN YOUR POSSESSION CONCERNING MY ILLNESS AND/OR TREATMENT DURING

PERIOD FROM _____ TO _____

PATIENT'S NAME _____ DATE_____

ADDRESS_____

SIGNATURE _____

WITNESS_____

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE TO:

_____

DOCTOR'S OFFICE OR HOSPITAL

_____

ADDRESS

COMPLETE MEDICAL RECORDS IN YOUR POSSESSION CONCERNING MY ILLNESS AND/OR TREATMENT DURING

PERIOD FROM _____ TO _____

PATIENT'S NAME _____ DATE _____

ADDRESS_____

SIGNATURE _____

WITNESS_____