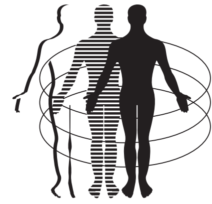
MRI of West Morris, P.A.

1.5T High Speed Short Bore MRI

Town Centre at Roxbury Mall
66 Sunset Strip, Suite 105, Succasunna, New Jersey 07876
Tel: 973-927-1010 • Fax: 973-927-7273



PATIENT REGISTRATION

PRINT NAME *(Last Name, First Name)* ______________________________

STREET ADDRESS ______________________ CITY ______________ STATE______ ZIP __________

HOME PHONE ______________________ SOCIAL SECURITY # ______________________

DATE OF BIRTH ______________ SEX __________ WEIGHT ______________ MARITAL STATUS __________

EMAIL ADDRESS ______________________________

EMPLOYER ______________________ WORK PHONE ______________________

EMPLOYER ADDRESS ______________________ CITY ______________ STATE______ ZIP __________

SPOUSE'S NAME ______________________ SPOUSE'S EMPLOYER ______________________

NAME OF NEAREST RELATIVE *(Not living with you)*______________________________

RELATIVE'S ADDRESS ______________________________ PHONE ______________

REFERRING DOCTOR ______________________________ PHONE ______________

PRIMARY INSURANCE

INSURANCE COMPANY ______________________

ID # ______________________

GROUP # ______________________

POLICY HOLDER'S NAME ______________________

POLICY HOLDER'S DOB ______________________

POLICY HOLDER'S SS # ______________________

RELATIONSHIP TO PATIENT ______________________

SECONDARY INSURANCE

INSURANCE COMPANY ______________________

ID # ______________________

GROUP # ______________________

POLICY HOLDER'S NAME ______________________

POLICY HOLDER'S DOB ______________________

POLICY HOLDER'S SS # ______________________

RELATIONSHIP TO PATIENT ______________________

IS THIS THE RESULT OF ANY TYPE OF ACCIDENT? ❑ YES ❑ NO *IF YES,* ❑ MVA ❑ WC DATE OF ACCIDENT ______________

ASSIGNMENT OF BENEFITS

PATIENT OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I irrevocably assign to MRI of West Morris, P.A. all my rights and benefits under any insurance contracts for payment for services rendered to me by MRI of West Morris, P.A. I irrevocably authorize all information regarding my benefits under any insurance policy relating to any claims by MRI of West Morris, P.A. to be released to MRI of West Morris, P.A. I irrevocably authorize MRI of West Morris, P.A. to file insurance claims on my behalf for services rendered to me. I irrevocably direct that all such payments go directly to MRI of West Morris, P.A. I irrevocably authorize MRI of West Morris, P.A. to act in my behalf and report any suspected violations of proper claims practices to the proper regulatory agency. Any unpaid balances will be subject to interest from the date of service.

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

SIGNED ______________________________ DATE ______________

PLEASE NOTE: Your insurance is a contract between you and your insurance carrier. We will cooperate with you in processing this claim. However, you are ultimately responsible for your financial obligations.

40002 05/15 2,500

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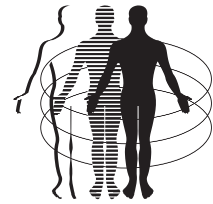

PATIENT CHECKLIST

PRINT NAME *(Last Name, First Name)* ______________________________

REFERRING PHYSICIAN ______________________________

1. Do you have a pacemaker? ❒ Yes ❒ No
2. Do you have intercranial clips? ❒ Yes ❒ No
3. Are you pregnant? ❒ Yes ❒ No
4. Have you ever had metal in your eyes? ❒ Yes ❒ No
5. Do you have any metal anywhere in your body? ❒ Yes ❒ No

   If yes, where? ______________________________
6. Have you ever had any heart surgery? ❒ Yes ❒ No
7. Have you ever had any brain or neck surgery? ❒ Yes ❒ No
8. Do you have a problem with claustrophobia? ❒ Yes ❒ No
9. Are you taking any blood thinners? (Aspirin, Plavix, Coumadin, etc.) ❒ Yes ❒ No

   If yes, what kind? ______________________________
10. Please describe your symptoms here: ______________________________

    ____

CERVICAL SPINE

1. Do you have pain or numbness down your arm? ❒ Yes ❒ No

   If yes, which arm? ❒ Left ❒ Right
2. Have you ever had surgery on your cervical spine? ❒ Yes ❒ No

LUMBAR SPINE

1. Do you have pain or numbness down your leg? ❒ Yes ❒ No

   If yes, which leg? ❒ Left ❒ Right
2. Have you ever had surgery on your lumbar spine? ❒ Yes ❒ No

BRAIN

1. Do you have headaches? ❒ Yes ❒ No
2. Do you have double vision? ❒ Yes ❒ No
3. Do you have one-sided body weakness? ❒ Yes ❒ No

   If yes, which side? ❒ Left ❒ Right
4. Do you have hearing loss in one or both ears? ❒ Yes ❒ No

   If yes, which side(s)? ❒ Left ❒ Right
5. Do you have a prior history of stroke or hemorrhage? ❒ Yes ❒ No
6. Have you had a recent head trauma? ❒ Yes ❒ No
7. Have you had any previous MRI, CT, or X-Ray examinations of the area(s) that will be scanned today? ❒ Yes ❒ No

   If yes, where were they done? ______________________________

PATIENT/GUARDIAN SIGNATURE ______________________________ DATE ______________

40003 05/17 2,500

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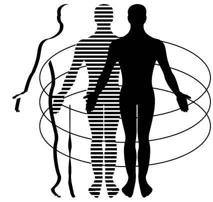

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I have been presented with a copy of Morris MRI Associates **Notice of Privacy Policies**, detailing how my protected health information may be used and disclosed for treatment, payment, and healthcare operations as permitted under federal and state law. I consent to such disclosure for these permitted uses, including disclosures via fax. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information:

____

____

I understand that the practice is not required to agree to the restrictions requested. Further, I permit a copy of this authorization to be used in place of the original, and understand that this document will remain in effect for 7 (seven) years from the original date of signing. I further understand that I may request additional restrictions, in writing, at any time by sending a request to the following address:

MRI of West Morris, P.A.
Attn: Privacy Officer
66 Sunset Strip, Suite 105
Succasunna, NJ 07876

Signed: ______________________________ Date: __________________

If not signed by patient, please indicate relationship to patient (e.g. spouse)

Relationship: ______________________ Witnessed by ______________________

AUTHORIZATION / REFERRAL POLICY

Many insurance companies have strict guidelines and policies with respect to authorizations and referrals for MRI procedures. Because these policies change on a regular basis, it is the responsibility of the patient to know what information is needed and what guidelines must be met according to his or her insurance company's policies in order to have an MRI examination.

I understand that I, the patient, am responsible for any payment related to any procedure for which I did not properly obtain a referral, or any procedure that I did not have properly authorized or pre-certified.

PRINT PATIENT'S NAME: ____

SIGNATURE: ______________________________DATE: __________________

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