MUNSTER
OPEN MRI & IMAGING

Patients Name: _____

Date of Birth: _____/_____/_____

Street Address: _____

City/State/Zip Code: _____/_____/_____

Home Phone #: _____/_____/_____

Cellular Phone #: _____/_____/_____

Social Security#: _____/_____/_____

Gender: MALE FEMALE

Marital Status: SINGLE/ MARRIED/ DIVORCED/ WIDOWED

Referring Physician: _____

Are you PREGNANT, or do you think you may be

PREGNANT? YES NO

If YES, pregnancy test results date: _____/_____/_____

I herby authorize my insurance to be paid directly to the above facility, realizing that I am responsible to pay non-covered services and I herby authorize the release of pertinent medical information to the insurance carriers.

Signature: _____

Date: _____/_____/_____

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Notice of Privacy Practice Acknowledgement

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in my care.
Obtain payment from third party payers
Conduct normal healthcare operations such as quality assessments and physician certifications

I understand the Notice of Privacy Practices. I understand that I may contact Munster Open MRI and Imaging at any time to request a current copy of the Notice of Privacy Practices.

I understand that I may request in writing how my private health information is used or disclosed to carry out treatment, payment of health care operations by Munster Open MRI and Imaging.

Patient Name: _____

Signature: _____

Date: _____/_____/_____