Open MRI

SOUTHERN MEDICAL IMAGING

1 Lincoln Parkway, Suite 105
Hattiesburg, MS 39402

PATIENT REGISTRATION

PATIENT INFORMATION

Referring Physician ______________ Primary Physician ______________

First Name ______________ Middle Initial _____ Last Name ______________

Date of Birth _____/_____/_____ Sex M ☐ F ☐ Social Security Number ______________

Mailing Address ______________

City ______________ State ______ Zip ______

Home Phone ( ) ______________ Alternate Phone ( ) ______________

Employer Name ______________ Employer Phone ( ) ______________

Employer Address ______________ City, ST, ZIP ______________

If patient is a student please indicate school attending: ______________ Email Address: ______________

Marital Status: ☐Single ☐Married ☐Widow ☐Divorced ☐Separated

PATIENT'S SPOUSE

First Name ______________ Middle Initial _____ Last Name ______________

Date of Birth _____/_____/_____ Sex M ☐ F ☐ Social Security Number ______________

Employer Name ______________ Employer Phone ( ) ______________

Employer Address ______________ City, ST, ZIP ______________

EMERGENCY INFORMATION *(Please list the name of someone who does not live with you to contact in the event of an emergency)*

Name ______________ Phone ( ) ______________

Address ______________

VISIT INFORMATION

Is this visit today work related? Yes ☐ No ☐ If yes, date of injury ______________

Is this visit today related to an auto accident? Yes ☐ No ☐

Is there a 3rd party involved? Yes ☐ No ☐ If so, Name______________ Insurance ______________

FINANCIAL POLICY

I am responsible for payment of services rendered to me by this clinic. (If the patient is under 18, the parent or legal guardian assumes responsibility of all charges.) Full payment is due at the time of service. I understand that if my account should ever require action by a collection agency or attorney in order to insure payment, the fees charged by these agents may be added to the balance due on the account. My signature below acknowledges understanding and agreement to the above reference policy.

______________________________ ______________

Patient Signature (Parent or Legal Guardian if minor) Date

INSURANCE INFORMATION

Primary Insurance Name ______________________________

Policy Number ______________ Group Number ______________ Effective Date __________

Name of Insured ______________________ Insured's Phone Number ( ) ______________

Insured's Date of Birth ____/____/____ Insured's Sex M ☐ F ☐

Address of Insured ______________________ City __________ ST ____ Zip ________

Relationship to Patient ______________________________

Secondary Insurance Name ______________________________

Policy Number ______________ Group Number ______________ Effective Date __________

Name of Insured ______________________ Insured's Phone Number ( ) ______________

Insured's Date of Birth ____/____/____ Insured's Sex M ☐ F ☐

Address of Insured ______________________ City __________ ST ____ Zip ________

Relationship to Patient ______________________________

Guarantor's Name ______________________ Guarantor's Date of Birth ____/____/____

Guarantor's Billing Address ______________________ Relationship to Patient ______________

City ______________ ST ____ Zip ________ Guarantor's Phone Number ( ) ______________

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Southern Neurologic & Spinal Institute's Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review the Notice before signing this consent. As provided in the notice, the terms or our Notice may change. If we change our Notice, you may obtain a revised copy by requesting a copy from our Administrative Office by writing 1 Lincoln Parkway, Suite 100 Hattiesburg, MS 39402.

You have the right to request that Southern Neurological & Spinal Institute restrict how protected information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to such a restriction, but if we do, are bound by our agreement. By signing this form, you consent to our use and disclosure of protected health information about your treatment and health care operations (including HIV testing and drug and alcohol screening, if applicable). You have the right to refuse signing this consent and the right to revoke this consent in writing, except when we have already made disclosures in reliance to your prior consent. This consent will expire two years from the date below.

Name: ______________________ ______________________ ______________

Name of Patient | Patient Signature (Parent or legal guardian) | Date

I am responsible for payment of services rendered to me by this clinic. (If the patient is under 18, the parent or legal guardian assumes responsibility of all charges.) Full payment is due at the time of service. I understand that if my account should ever require action by a collection agency or attorney in order to insure payment, the fees charged by these agents may be added to the balance due on the account. I authorize Southern Neurologic & Spinal Institute and all employees and other personal of/or associated with Southern Neurologic & Spinal Institute to have access to my existing and future medical records and copies thereof in connection with all medical services or treatment under confidentiality which I may now of hereafter receive from the staff.

I hereby also authorize payment of medical benefits to Southern Neurologic & Spinal Institute for all services provided to me. I authorize the physician to release any information acquired in the course of my treatment to process insurance claims, workers compensation claims, or any other agent that has been involved in my medical treatment. I also permit release of medical information to continue the process of care on my behalf. All other releases will require a release of information form to be completed.

I hereby acknowledge and agree to accept the policies as stated above.

______________________________ ______________________

Signature of Patient (Parent or Legal Guardian) | Date