Registration

Open MRI of St. Joseph

Legal Name: _____

Address: _____

Zip Code: _____

Gender: M / F

Birth Date: _____

Social Security #: _____

Cell Phone: _____

Home Phone: _____

Work Phone: _____

Alternate Contact: _____

_____

Primary Insurance: _____

I.D. #: _____

Group # (if applicable): _____

Insured Name: _____

Birth Date: _____

Social Security #: _____

Secondary Insurance: _____

I.D. #: _____

Group # (if applicable): _____

Insured Name: _____

Birth Date: _____

Social Security #: _____

Workers Compensation

Employer: _____

Bill to: _____

Claim #: _____

Contact Person and Phone: _____

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number. Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

It is understood and agreed that all professional services must be paid for at the time the service is rendered unless prior arrangements are made with the office. Even though an insurance claim may be filed, you are responsible for the total amount of your account and will receive a statement if your account has a balance due. This office cannot accept responsibility for collecting your insurance claim or negotiating a settlement on a disputed claim. I authorize the release of any medical or other information necessary to process a claim and payment of medical benefits to the treating physician.

Signature of person completing form: _____ Date: _____

Form completed by: ☐ Patient ☐ Parent ☐ Guardian