

Champlain Valley Open MRI

Accredited by the American College of Radiology

118 Consumer Square • Plattsburg, NY 12901 • Phone (518) 562-3650 • Fax (518) 562-3801

PATIENT REGISTRATION FORM

Chart # _____

To ensure prompt payment of your insurance claim, please fill in ALL Information

Date _____ Time _____ Ordering Physician _____ Phone # _____

If today's visit is related to an accident: Date of Accident _____ Work Related Auto Accident (State _____) Other

PATIENT INFORMATION:

Last Name _____ First _____ Initial _____

Address _____ City _____ State _____ Zip Code _____

Patient SS# _____ Date of Birth _____ Age _____

Single Divorced Widow Sex (F/M) _____ Student Status Full Time Part Time
 Married Spouse's Name _____ Non Student

Home Phone: Area Code (_____) _____ - _____

Patient's Employer: _____ Location _____ EMERGENCY CONTACT: _____
(Other than Spouse)

Employment Status: Full Time Part Time Not Employed Area Code (_____) - _____ - _____

Work Phone #: Area Code (_____) _____ - _____ Relationship to Patient _____
 Retired Retirement Date _____ (Friend, Mother, Father, Etc.)

Thank You For Taking a Few Moments To Assist Us With The Information Necessary To File Your Insurance Claim.

We Will Copy Your Card However Some Information Is Not On Your Card.

PRIMARY INSURANCE POLICY:

Last Name _____

First _____ Initial _____

Insurance Company _____

Address _____ City _____ ST _____ ZIP _____

Policy ID # _____ Group/Claim # _____

Relationship: Self Spouse Child Other

SECONDARY INSURANCE POLICY:

Last Name _____

First _____ Initial _____

Insurance Company _____

Address _____ City _____ ST _____ ZIP _____

Policy ID # _____ Group/Claim # _____

Relationship: Self Spouse Child Other

If Policyholder is Other Than Patient:

Date of Birth _____ SS# _____

Employer _____

Address _____

City _____ ST _____ Zip Code _____

If Policyholder is Other Than Patient:

Date of Birth _____ SS# _____

Employer _____

Address _____

City _____ ST _____ Zip Code _____

Release Agreement: By my signature below, I am entering into an agreement with Champlain Valley Open MRI as follows.

1. I request that **Champlain Valley Open MRI** render medical services to me.
2. I authorize **Champlain Valley Open MRI** to release information regarding my medical condition and treatment to my insurance company, attorney, employer and/or any other health care professional involved in my medical care.
3. I understand that I am fully responsible for payment of all charges resulting from such authorized medical treatment and that such charges are due and payable the time of service, unless I have made other arrangements regarding a fee payment schedule.
4. I authorize benefits to be paid directly to **Champlain Valley Open MRI** who will adjust the disallowed amount shown on the explanation of benefits for insurance companies with which they have a written participating contract agreement.
5. I understand that it is my responsibility to verify the coverage and benefits of my insurance policy with "member Services" (phone number found on the back of most cards) and I will be responsible for all co-payments and deductibles, and non-covered services as described on my explanation of benefits.
6. I understand I will be responsible for all co-payments and deductibles, and non-covered services as described on my explanation of benefits.
7. I authorize **Champlain Valley Open MRI** to share my imaging studies (with all patient identifying information removed) with other physicians and medical professionals for educational purposes.
8. I authorize **Champlain Valley Open MRI** to obtain medical records from other physician offices pertaining to the procedures performed today.

Signature _____

Date _____

IF YOU ARE UNINSURED PLEASE ASK ABOUT OUR PAYMENT ARRANGEMENT PLANS