

## PATIENT INFORMATION SHEET

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
S.S. No.: \_\_\_\_\_ Name of Parent if Minor: \_\_\_\_\_  
Phone #: Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_  
Residence Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Mailing Address: Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Family Physician: \_\_\_\_\_ Referring Physician: \_\_\_\_\_

### PATIENT'S (OR PARENT/GUARDIAN) EMPLOYER INFORMATION

If parent, name: \_\_\_\_\_ Social Security #: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Employed by: \_\_\_\_\_ Work Phone #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Company Address: Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

### SPOUSE (OR PARENT/GUARDIAN'S SPOUSE) INFORMATION

Name of Spouse: \_\_\_\_\_ Social Security #: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Employed by: \_\_\_\_\_ Work Phone #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Company Address: Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Are you currently a resident in a skilled nursing facility/nursing home? (circle one) Yes No  
Length of residency?(circle one) Short term Long term

## EMERGENCY INFORMATION

### RELATIVE NOT LIVING WITH YOU

Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Relationship: \_\_\_\_\_

## INSURANCE INFORMATION

Circle one: **FOR MOTOR VEHICLE** **WORKMAN'S COMP** **HEALTH INSURANCE**  
Date of Accident: \_\_\_\_\_ Company's Name: \_\_\_\_\_  
Company's Address: Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
•••••VERY IMPORTANT \*\*\*\*\* Claim No.: \_\_\_\_\_  
Policy: \_\_\_\_\_ Adjuster Name: \_\_\_\_\_  
Adjuster Phone #: \_\_\_\_\_ State, if other than PA: \_\_\_\_\_

### HEALTH INSURANCE INFORMATION FOR ALL PATIENTS

a) Primary Insurance Co.: \_\_\_\_\_  
b) Secondary Insurance Co.: \_\_\_\_\_

Date: \_\_\_\_\_ Patient: X \_\_\_\_\_  
(Or Authorized Representative)

## AUTHORIZATION AND AGREEMENT FOR PAYMENT

I understand that I am fully responsible for all fees payable to **POCONO MRI DIAGNOSTIC & IMAGING CENTER** for medical treatment rendered to me or a member of my family.

I authorize payment of all medical benefits for services rendered by **POCONO MRI DIAGNOSTIC & IMAGING CENTER**.

In the event that I am denied insurance coverage, or my information provided is incorrect, invalid and/or missing I will make arrangements to pay bills within thirty (30) days.

I understand that I am entering into a contractual relationship with **POCONO MRI DIAGNOSTIC & IMAGING CENTER** and my physician for professional care. I further understand that meritless and frivolous claims for medical malpractice have an adverse effect upon the cost and availability of medical care, and may result in irreparable harm to a medical provider. As additional consideration for professional care provided to me by **POCONO MRI DIAGNOSTIC & IMAGING CENTER** and my physician, I and/or my representative agree not to advance, directly or indirectly, any false, meritless, and/or frivolous claim(s) of malpractice against **POCONO MRI DIAGNOSTIC & IMAGING CENTER** and my physician.

Furthermore, should a meritorious medical malpractice case or cause of action be initiated or pursued, I and/or my representative agree to use ABMS board-certified expert medical witness(es) in the same or similar specialty as my physician. Furthermore, I agree that these expert witnesses will adhere to the guidelines and / or code of conduct defined by the specialty society(ies) for expert witnesses in the area(s) of medicine that would typically have the background and experience to opine on such a case. In further consideration for this, **POCONO MRI DIAGNOSTIC & IMAGING CENTER** and its physicians agree to the same stipulations.

By my signature, I certify that I have read and understood the above or that all the above provisions have been fully explained to me.

Date: \_\_\_\_\_

Patient: \_\_\_\_\_  
(Or Authorized Representative)

## ATTENTION MEDICARE PATIENTS

NAME OF PATIENT: \_\_\_\_\_

(OR AUTHORIZED REPRESENTATIVE)

PATIENT'S MEDICARE CARD #: \_\_\_\_\_

I request that payment of authorized Medicare benefits be made on my behalf to **POCONO MRI DIAGNOSTIC & IMAGING CENTER** for any services furnished me by that physician/supplier who accepts assignment. I authorize any holder of medical information about me, to release to the Center for Medicare and Medicaid Services (CMS/formerly HCFA) and its agents any information needed to determine these benefits payable for related services. I also understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.) Regulations pertaining to Medicare assignment of benefits apply.

### MEDIGAP AUTHORIZATION STATEMENT

I authorize any holder of medical or other information about me to release to the Social Security Administration and Center for Medicare and Medicaid Services or its intermediaries or carrier or any other insurance company any information needed for this or a related Medicare/Other Insurance company or a related Medigap claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to be made to the party who accepts assignment

Date: \_\_\_\_\_

Patient: \_\_\_\_\_  
(Or Authorized Representative)