HUNTERDON RADIOLOGICAL ASSOCIATES, P.A. / HUNTERDON IMAGING, P.A.

PATIENT INFORMATION

Patient Name: _____

Date of Birth: _____ **Social Security:** _____ **Sex**: _____

Ethnicity: __ Latino/Hispanic __ Other __ Decline to answer

Race: __Caucasian __Black __Asian __American Indian/Alaskan Native __Native Hawaiian/Other Pacific Islander

__ More than one race __ Other Race or Ethnicity __ Decline to answer

Is English your preferred language? Yes / No If not, please specify: _____

_____ _____ _____

Home Phone **Cell Phone** **Email address**

Address (Street, Apt. #, City, State, Zip Code)**:** _____

Employer Name: _____ **Phone:** _____

Preferred Contact Method(s) for appointment reminders & billing purposes – *check all that apply*:

___Text ___Mail ___E-Mail ___ Home Phone – may we leave a message? __ Yes ___ No

___ **Cell Phone** – may we leave a message? __Yes __No ___**Work Phone -** may we leave a message? __ Yes ___ No

EMERGENCY CONTACT

_____

Name **Patient's Relationship to Contact** **Contact Phone**

Is today's visit a result of an accident or injury? Yes / No **If yes, please select one:**

_____ Workers' Comp injury Date of injury: _____ Is the workers' comp claim still active?: Yes / No

____ Automobile accident Date of Accident: _____

- On your PIP policy, who have you elected to be your primary insurer for medical bills?
  ___ Automobile insurance carrier ___ Health insurance carrier
- Is the no-fault claim still active?: Yes / No

____ Other accident or injury (Please explain) _____

PRIMARY INSURANCE INFORMATION

Plan Name: _____

Policy Number: _____ **Group Number:** _____

Policyholder Name: _____ **DOB:** _____ **SSN:** _____/_____/_____

Address: _____

Home Phone: _____ **Cell Phone:** _____

Employer Name: _____ **Work Phone:** _____

Address: _____

SECONDARY INSURANCE INFORMATION:

Plan Name: _____

Policy Number: _____

Group Number: _____

Policyholder Name: _____

DOB:_____ **SSN:** _____/____/_____

Address: _____

_____

Home Phone: _____ **Cell Phone:** _____

Employer Name: _____ **Work Phone:** _____

Address: _____

TERTIARY INSURANCE INFORMATION

Plan Name: _____

Policy Number: _____**Group Number:** _____

Policyholder Name: _____**DOB:** _____

SSN: ___/___/_____

Address: _____

Home Phone: _____ **Cell Phone**: _____

Employer Name: _____**Work Phone**:_____

Address: _____

PATIENT CONSENT TO RELEASE INFORMATION TO FAMILY MEMBERS, CLOSE FRIENDS, CAREGIVERS

Please list individual(s) we are authorized to speak with regarding your care. The HIPAA Privacy Rule specifically permits us to share information that is directly relevant to your spouse, family members, friends, or other persons identified by you with your consent.

This consent maybe revoked at any time by providing a written request to Hunterdon Radiological Associates, P.O. Box 5388 Clinton, NJ 08809, and Attention: Compliance Officer.

Contact person: _____ Relationship: _____ Phone Number: _____
Contact person: _____ Relationship: _____ Phone Number: _____
Contact person: _____ Relationship: _____ Phone Number: _____

_____ _____
Signature of Patient, or if Patient is unable to sign, a representative of the Patient **Date**

_____ _____
Relationship to Patient (if patient is unable to sign) **Reason patient Unable to Sign**

FINANCIAL DISCLOSURE STATEMENT

I understand that the patient or guarantor is responsible for any charges incurred at Hunterdon Radiological Associates, P.A/Hunterdon Imaging, P.A., regardless of insurance coverage. I also authorize you to release information concerning my exam to my insurance Company and/or physicians. **For Medicare/Medicaid patients:** I request that payment of authorized Medicare/Medicaid benefits be made to me or on my behalf to Hunterdon Radiological Associates, P.A./Hunterdon Imaging, P.A., for the services rendered.

Signature of Patient or Guardian: _____ **Date:** _____

Receipt of Privacy Policy/Financial Policy _____ (Please initial) Employee Initials: _____

If you are 18 years of age or older and someone else is responsible for your medical bills, pays your medical bills, or helps you with your medical bills, please provide the name, phone number and relationship of that person. By so doing, this will confirm your consent for us to speak with that person regarding your medical information as well as your financial responsibility. Please understand, this does not waive your legal responsibility for payment of charges incurred at Hunterdon Radiological Associates, P.A/Hunterdon Imaging, P.A.

Name: _____ **Relation to Patient:** _____

Phone Number: _____