Site:_____

Cooperative Magnetic Imaging

OUTPATIENT

Copay Amt and Type:_____

Today's date:	Referring MD:		MRN#		
Patient's last name:	**First:**	**M.**	**(Maiden name):**	**Birth date:**	
				/ /	
Street address:		**City, State**	**Zip Code**	**Age:**	**Sex:**
					❑ M ❑ F
Social Security no.:	**Home Phone no.:**	**Cell no.:**	**Employer Name and Phone #:**		
	( )	( )			
Insurance Company(s):	**Subscriber Name:** *(if other than patient)*	*Circle One:* **Spouse Parent Other:** _____	**Subscriber date of birth:**		
No Fault or Worker's Comp. case (circle one) ?	**Emergency Contact Person:**	**Relationship:**	**Home phone no.:**		
Y or N :If yes, _____			( )		

- RESPONSIBILITY FOR PAYMENT: I understand that I am personally financially responsible to CMI and Practice Management Services for charges I have incurred that are not covered by the assignment of benefits.
- PAYMENT @ TIME OF SERVICE (self pay): I understand that I am required to pay 100% of my charges at time of service, unless I have a medical insurance carrier in which CMI and PMS participates with and can show proof (current valid insurance card) of such coverage or have made other arrangements with CMI and Practice Management Services.
- NO FAULT/WORKER'S COMPENSATION: I understand that CMI and PMS will bill NYS No Fault Insurance on my behalf. I understand that CMI and PMS will bill Workers Compensation Insurance on my behalf. If I fail to prosecute this claim or it is denied or disallowed I agree to assume full financial responsibility.
- AUTHORIZATION: I hereby authorize the release to CMI and PMS any medical, insurance or other information needed for this service or related medical condition or claim. I hereby authorize the release of medical information to my insurance carrier and referring provider. I hereby authorize my insurance carrier to direct the payment of my medical benefits to Practice Management Services for the services provided to me by the professional staff of CMI. I am aware of CMI's Notice of Privacy Practices and that I have the right to request further information as needed. This authorization may be conveyed by original signature or photocopy, which shall be as valid as the original.

1. Notwithstanding that this bill may be submitted for insurance, patient and his/her legal/authorized representative(s) acknowledge responsibility for the balance shown on the patient statement for services rendered.
2. Patient agrees that, in the event proceedings are instituted to collect monies due for services, that the patient waives all jurisdiction and venue requirements, and that venue and jurisdiction hall lie in Oneida County, in either Utica City Court or Supreme Court, or in Herkimer County in the Little Falls County Court or Supreme Court, and if the patient is found liable, also agree to be responsible for reasonable legal fees and costs related to such proceedings.

I authorize CMI and Practice Management Services to obtain and/or release films and medical information necessary for treatment, payment and /or healthcare operation. This authorization shall remain in effect until revoked by the patient.

- CMI acknowledges the patient's right an Advance Directive in accordance with NYS law. Please place your initials next to the appropriate statement(s) below.

_____ I HAVE an Advance Directive in place: (if yes: check which) _____ Healthcare Proxy _____ Living Will _____ DNR

_____ I DO NOT have an Advance Directive, but have been offered an informational packet for my review.

Date: _____ _____ _____

Signature of patient or parent/guardian CMI Witness

Site:_____

Kt 08-13