MAGNETIC DIAGNOSTIC RESOURCES OF CENTRAL NEW YORK, LLP

PATIENT DEMOGRAPHICS

Patient Name (Last, First, Middle) ______________________

Date of Birth ________ Email ______________________

Street Address ______________________

City ______________, State ______, Zip Code ________

Home Phone ____________ Cell Phone ____________

Parent/ Legal Guardian ______________ Relationship to Patient ______________

Date of Birth ________ Email ______________________

Street Address ______________________

City ______________, State ______, Zip Code ________

Home Phone ____________ Cell Phone ____________

NO FAULT INSURANCE INFORMATION

Auto Accident Injury (NO FAULT)? Yes ☐ **No** ☐

Date of Auto Accident: ______/______/_______

Insurance Carrier ______________________

Address/City/State/ZIP ______________________

Claim # ______________________

WORKER'S COMPENSATION INFORMATION

Workplace Injury (WORKER'S COMP)? Yes ☐ **No** ☐

Date of Worker's Comp Injury: ______/______/_______

Employer and Address ______________________

Insurance Carrier and Address ______________________

Claim # ______________________

INSURANCE INFORMATION - No need to fill out if we made a copy of your card(s).

Primary Insurance Carrier ______________ Effective Date ________

Policy Holder Name ______________________

Subscriber ID # ______________ Group # ________

Relationship to Patient ________ Policy Holder Employer ______________

Secondary Insurance Carrier ______________ Effective Date ________

Policy Holder Name ______________________

Subscriber ID # ______________ Group # ________

Relationship to Patient ________ Policy Holder Employer ______________

1. I have been offered a copy of the *Notice of Privacy Practices* at Magnetic Diagnostic Resources of CNY, LLP and have been given the opportunity to read and ask questions.

   Authorized Signature: *X*______________________________ Date: *X* ____________________

2. As per *Notice of Privacy Practices*, I authorize the release of information for treatment, payment, healthcare operations, and contacting you.

   Authorized Signature: *X*______________________________ Date: *X* ____________________

3. I authorize my insurance benefits to be paid directly to Magnetic Diagnostic Resources of CNY, LLP and I acknowledge that I am financially responsible for any co-payment, deductibles, and non-covered services.

   Authorized Signature: *X*______________________________ Date: *X* ____________________

4. I have been made aware of the MDR *Appointment No Show Policy* of $50 to be billed to me for any future missed appointments at MDR (Medicaid and Managed Medicaid insurances excluded).

   Authorized Signature: *X*______________________________ Date: *X* ____________________