MAGNETIC DIAGNOSTIC RESOURCES OF CENTRAL NEW YORK, LLP

PATIENT DEMOGRAPHICS

Patient Name (Last, First, Middle): _____ Date of Birth: _____

Street Address: _____, City: _____, State: _____, Zip Code: _____

Home Phone: _____ Cell Phone: _____ Height: _____'_____" Weight: _____ lbs.

☐ The patient is a minor and resides at the same address as the parent/legal guardian. Name of Parent/Legal Guardian: _____

☐ The patient is a minor and does not reside at the same address as the parent or legal guardian. Name, Address and Phone#: _____

_____

Check applicable insurances boxes for this appointment and provide name of your insurance company:

☐ Primary Insurance: _____

☐ Secondary Insurance: _____

☐ No Fault Insurance: _____ Claim #: _____

☐ Worker's Comp. Insurance: _____ Claim #: _____

Staff Initials: _____

PATIENT AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

I authorize Magnetic Diagnostic Resource of CNY, LLP (MDR) to use and disclose certain PHI about me to or for the parties below. This authorization permits MDR to use or disclose certain PHI about myself, including dates of service, level of information detail, the origin of information, and financial matters. I understand that when my information is used or disclosed under this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I have the right to revoke this authorization in writing except to the extent that MDR has acted in reliance upon this authorization. I understand that a written revocation must be submitted to the Privacy Officer at MDR of CNY, LLP, 5000 Brittonfield Parkway, Suite A114, E. Syracuse, NY 13057.

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

I authorize and permit MDR to allow the release of my PHI to the individuals listed above.

Authorized Signature: X_____ Date: X _____

1. MDR offered a copy of the *Notice of Privacy Practices* at Magnetic Diagnostic Resources of CNY, LLP, and allowed me 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 for appointment-related questions.

   Authorized Signature: X_____ Date: X _____

3. I authorize my insurance benefits to be paid directly to Magnetic Diagnostic Resources of CNY, LLP. I acknowledge that I am financially responsible for co-payments, 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 _____