REDI DIAGNOSTICS CORP

ONE BROADWAY, ELMWOOD PARK NJ 07407
TEL: (201) 773-4255 FAX: (201) 773-3160

(PATIENT INFORMATION)

Date _____ Soc Sec # _____ Birthday_____

Name _____
Last First Initial

Address _____ Home Phone _____

City _____ State_____ Zip _____

SEX: ☐ M ☐ F ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Employer _____ Business Phone _____

Employer Address _____ Occupation _____

Who should we thanks for referring you? _____

In case of emergency, who should we contact? _____Phone _____

(PRIMARY INSURANCE)

Person responsible for Account _____
Last Name First Name Initial

Relationship to Patient _____Birthday _____ Soc Sec# _____

Address _____ Home Phone _____

City _____ State_____ Zip _____

Responsible Party Employed By _____ Business Phone_____

Business Address _____ Occupation_____

Insurance Company _____ Insurance Company Address _____

Subscriber ID # _____ Group# _____

(ADDITIONAL INSURANCE)

Insured Name _____
Last Name First Name Initial

Relationship to patient _____Birthday_____ Soc.Sec # _____

Address _____ Home Phone _____

City _____ State _____ Zip _____

Insured Employed By _____ Business Phone _____

Insurance Company _____Insurance Company Address _____

Subscriber ID # _____Group# _____

(ACCIDENT INFORMATION)

Date of accident/Injury _____/_____/_____ Location _____

Car accident _____ Worker's Comp _____ Slip & Fall _____

Vehicle is: (Own car) (Family car) (Commercial Vehicle) (Other)

Patient was: (Passenger) (Driver) (Pedestrian) (Bicyclist) (Motorist) (Other)

Auto Insurance Carrier _____

Address _____ City _____ State_____ Zip _____

Adjuster Name _____ Phone _____ Policy # _____

Claim # _____ Insured Date _____/ _____/_____ Insured's SS# _____

Spouse _____ Parent _____ Other_____

SIGNATURE OF PATIENT _____ DATE_____

MRI PATIENT QUESTIONNAIRE/ *(MRI PREGUNTAS A CONTESTAR)*

Please answer the following questions. Do not hesitate to speak with our office staff with any questions/
Por favor conteste todas las preguntas. No resista hablar con nuestro colaboradores por alguna inquietude

Name/*Nombre* _____ Date of Birth/*Fecha de Nacimiento* _____

Please indicate the symptoms you are having for today's examination. Please check:
Favor indique los sintomas que usted esta teniendo en este momento antes de la examinacion

_____ Headache/ *Dolor de cabeza*	_____ Knee(Right/Left) /*Rodilla(Izq/Der)*
_____ Vission Loss / *Vision borrosa*	_____ Neck pain / *Dolor cuello*
_____ Dizziness / *Mareos*	_____ Mid. back pain / *Dolor espalda(el medio)*
_____ Numbness / *Temblores*	_____ Lower back pain / *Dolor espalda baja*
_____ Ringing in ears / *Zumbido en oidos*	_____ Abdominal pain /*Dolor abdominal*
_____ Shoulder (Right/ Left) Hombros (Izq/Der)	_____ Foot (Right/ Left) Pies *(Izq/ Der)*
_____ Arm (Right/ Left) Brazos (Izq/Der)	_____ Ankle (Right/Left) *Tobillo (Izq/Der)*
_____ Wrist/Hand (Right/Left) *Muñeca /Mano (Izq/Der)*	_____ Other / *Otros*
_____ Leg (Right/Left) Piernas (Izq/Der)	_____ Pain / *Dolor* 1.2.3.4.5.6.7.8.9.10

2. How long have had above symptoms ? / *Hace cuanto tiempo tiene los sintomas mencionados arriba.*
3. Do you have a history of diabetes? / *Ha tenido un pasado diabectical* ? Yes/*Si* _____ No_____

4. Is this result of the injury and/or accident?/ *Es este el resultado de caida,golpe / accidente?*
Yes/*Si* _____ No _____ If yes, please describe your injury and/or accident / *Si dijo que si, favor describa como ocurrio su caida/accidente*

5. Have you had prior imaging studies of the body part being examined today? / *Ha tenido algun anterior studio magnetico de la parte ha ser examinada hoy ?* Yes/*Si* _____ No_____

6. Have you had any previous surgeries that resulted in having metal in your body? / *Ha tenido alguna cirugia que haya resultado con un metal en su cuerpo*? Yes/Si _____ No _____ If yes, please describe/ *Si dijo que si favor describirla.*

7. Have you ever had any previous surgeries on the part of the body being examined today? / *Ha tenido alguna previa cirugia en la parte de su cuerpo ha ser examinada hoy*? Yes/*Si* _____ No_____ If yes, please decribe/ *Si dijo que si , favor describa*

8. Have you ever done any welding, grinding or cutting of metal? / *Ha hecho alguna vez algo de soldar, moldear or cortar metal?* Yes / *Si* _____ No _____

9. Is there any possibility of metal in your eyes? /*Hay alguna posibilidad de tener metales en sus ojos*? Yes/ *Si* _____ No _____

10. Have you ever had or do you now have cancer? / *Ha padecido o padece ahora de cancer?* Yes/*Si* _____No_____

11. Do you have any kidney disease? / *Padece de alguna enfermedad renal?* Yes/*Si* _____ No _____

12. Is there any chance that you are pregnant? / *Hay alguna posibilidad de un embarazo?* Yes/ *Si* _____ No_____

13. Are you breast – feeding ? / *Esta usted dando el pecho ?* _____

14. If a contrast injection is a deemed necessary by the ordering physician or the radiologist / *Si una inyeccion especial de imagines es estimada necesaria por su doctor primario o el radiologo* I/*Yo* _____ give consent to be given the contrast injection / *Doy el consentimiento para recibir la inyeccion especial de imagines.*
15. Do you have any drug allergies or any other allergies?_____
*/ Tiene usted algún tipo de alergia o es alergico (a) a alguna medicinas?*_____

PATIENT SIGNATURE/ *FIRMA DEL PACIENTE* _____DATE/*FECHA* _____

PATIENT'S NAME: _____ DATE: _____

ASSIGNMENT OF BENEFITS

Patients Name: _____

I irrevocably assign to **REDI Diagnostics Corp**., my medical provider, all my rights and benefits under my insurance contract for payments services rendered to me.

I irrevocably authorize all information regarding my benefits under any insurance policy relating to any claim by **REDI Diagnostics Corp**., to be released to REDI Diagnostics Corp.

I irrevocably authorize **REDI Diagnostics Corp** to file Insurance claims on my behalf for services rendered to me as a result of this automobile accident and this specifically includes filing arbitration/litigation in your name on my behalf against the PIP/health care carrier. I irrevocably direct that all such payments go directly to REDI Diagnostics Corp., my medical provider.

I irrevocably authorize **REDI Diagnostics Corp**., to act on my behalf. I consent to your acting on my behalf in this regard and in regard to my general health insurance coverage pursuant to the benefits denial process set forth in the NJ Administrative Code and report any suspected violations of proper claims practices to the proper regulatory authorities.

In the event the insurance carrier responsible for making medical payments in this matter does not accept my assignment, or my assignment is deemed invalid, I execute this limit power of attorney and appoint your collection attorney as my agent to collect payment for your medical services directly against the carrier in this case including filing an arbitration demand or lawsuit. I specifically authorize that attorney to file directly against that carrier in my name or in your name as a medical provider rendering services to me.

This assignment of benefits has been explained to my full satisfaction and I understand its nature an effect.

FINAL POLICY

Any services that are not covered by your insurance are your responsibility and will be due and payable upon receipt or a billing statement. If correct insurance information or referral is not presented at the time of service, you are responsible for the full amount of charges incurred. If you do not have medical insurance, financial arrangements will be made.

SIGNATURE OF PATIENT/GUARDIAN DATE

CONSENT FOR PATIENT OR MINOR FOR A DIAGNOSTIC IMAGING PROCEDURE

The procedure has been explained to me in detail and I as the patient or legal guardian/ parent of _____ understand it and agree to it.
I hereby give my consent for MRI/US studies to be performed by REDI Diagnostics Corp.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize REDI Diagnostics Corp., and is associated to provide radiological treatment and/or examination and release any information per patient to my case in the course of my examination or treatment to my physician, insurance company, adjuster, or attorney if applicable in this case.

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE TO:

REDI DIAGNOSTICS CORP.
ONE BROADWAY SUITE 102
ELMWOOD PARK, N.J. 07407

COMPLETE MEDICAL RECORDS IN YOUR POSSESION CONCERNING MY ILLNESS AND/OR TREATMENT DURING

PERIOD FROM _____ TO _____

PATIENT'S NAME _____ DATE _____

ADDRESS _____

Patient rights had been presented to me at the time of the appointment.

_____

SIGNATURE OF THE PATIENT/GUARDIAN DATE

REDI DIAGNOSTICS CORP
ONE BROADWAY SUITE 102
REDI DIAGNOSTICS CORP
ONE BRADWAY, SUITE 102
ELMWOOD PARK, NJ 07407

HIPAA-NJ PRIVACY MANUAL

CONSENT FOR USE AND DISCLOSURE FORM

(For Treatment, Payment and Health Operations)

I _____understand that in the course of providing care to me the
(Print name)
Practice will receive, create, maintain and disclose information about me for the purpose of the Practice's and other health provider's provision of treatment, securing payment from me, an insurer, other third-party payer or responsible party, and/or in connection with the health care operations of the Practice and/or the operations other health providers who have treated me and as otherwise required or permitted by State and/or Federal Law. I understand that a further description of these anticipated uses and disclosures of my health information appears in the Practice's Notice of Privacy Practices.

Except for genetic information, I agree to the sharing, utilization, examination and disclosure of any of my health information, including but not limited to known or suspected HIV/AIDS infection, mental health records, communicable disease, substance abuse and/or treatment, if applicable, as is reasonable necessary by the Practice, its employees and other members of its workforce for the limited purpose of rendering treatment, securing payment for treatment, if rendered and conducting the Practice's operations. I further agree to the disclosure by the Practice of such information, as is reasonably necessary, to other health providers involved in my treatment and their employees and other members of their workforce for treatment, payment and health operations, to any private or governmental insurer, including Medicaid and Medicare and its intermediaries and agents, other third-party payers, or other financially responsible party for the purpose of determining benefits and securing payment, and as otherwise permitted by State and/or Federal law.

This consent may be revoked at any time but, only to the extent that the Practice has not acted in reliance on it. If not previously revoked, this consent will remain valid as long as I am a patient of the Practice and from such period of time thereafter as is reasonably necessary to serve the purpose for which it was given; namely, the provision of treatment, securing payment for services rendered and conducting health operations.

_____ _____

Date Signature of patient or legal representative
(if signed by a representative, print title
(e.g., parent/guardian, power of attorney)