



Patient Name _____

Registration # _____

() _____
Primary Phone Mobile
 Work
 Home

() _____
Secondary Phone Mobile
 Work
 Home

() _____
Tertiary Phone Mobile
 Work
 Home

Email Address: (Please Print Neatly) _____

Would you prefer if we send you appointment reminders by email?

Yes No

How would you like our staff to address you when being called from the waiting area? _____

I attest that within the last 30 months, I have seen and am a patient of the physician listed below, to whom I would like you to send today's radiology report.

Patient Signature

1) (Required)

Name

Telephone # Fax #

- Mammo
- Sono
- MRI
- Biopsy
- Bone Densitometry
- Other

Address

2) (Only if necessary)

Name

Telephone # Fax #

- Mammo
- Sono
- MRI
- Biopsy
- Bone Densitometry
- Other

Address

3) (Only if necessary)

Name

Telephone # Fax #

- Mammo
- Sono
- MRI
- Biopsy
- Bone Densitometry
- Other

Address

I authorize the release of my medical reports to my insurance carrier and any of my physicians, if requested by them.

I further acknowledge that a copy of rights under HIPAA have been supplied to me.

Patient or Authorized Signature

Date

Please see reverse

Dear Patient,

Please be advised that Medical Imaging of Manhattan does not participate with any medical insurance plans and has opted out of Medicare.

If you are here today for a Screening Mammogram and your last Mammogram was less than one year ago, please be advised that your insurance carrier **might not** reimburse you for your mammogram today.

If you choose **not** to have consultation with a radiologist today, the standard images will be taken by the technologist, and you will receive your results in the mail within 5 business days.

Once you have paid for your visit in full, you will be given a receipt to submit to your insurance carrier for reimbursement. No claim can be submitted by you or this office to Medicare.

Please keep in mind that depending upon the type of coverage you have, your insurance carrier may or may not acknowledge the claim fully or at all. Although we will try to help you, Medical Imaging of Manhattan is not responsible for any reimbursement or denial you receive.

- I **do** have Medicare insurance.
- I **do not** have Medicare insurance.

I understand and accept the terms described above:

Signature

Print Name

Date