STOCKTON M R I

MEDICAL CENTER, INC.
2320 N. CALIFORNIA ST.
STOCKTON, CA 95204

REFERRING PHYSICIAN _____ DATE _____

PATIENT NAME _____ ❑ Male ❑ Female
Last First Middle Initial

DATE OF BIRTH _____ AGE _____ HOME PHONE ( ) _____ WORK PHONE ( ) _____

MAILING ADDRESS _____
Street Address Apt.# City State Zip Code

PATIENT ADDRESS _____
Street Address Apt.# City State Zip Code

PATIENT SOCIAL SECURITY NUMBER _____

PATIENT EMPLOYER/SCHOOL _____

PLEASE CIRCLE THE APPROPRIATE ANSWERS. **HISTORY OF KIDNEY DISEASE OR DIABETES?** YES / NO
ARE YOU ALLERGIC TO? **SHELL FISH** YES / NO **IODINE** YES / NO **X-RAY CONTRAST** YES / NO
FEMALE PATIENTS ONLY: ARE YOU PREGNANT OR BREAST FEEDING YES / NO

PATIENT STATUS: A. ❑ Single ❑ Married ❑ Other
B. ❑ Employed ❑ Full-Time Student ❑ Part-Time Student

SPOUSE/PARENT _____ SOCIAL SECURITY # _____

DATE OF BIRTH _____ HOME PHONE ( ) _____ WORK PHONE ( ) _____

ADDRESS _____
Street Address Apt.# City State Zip Code

EMPLOYER _____

PERSON RESPONSIBLE FOR PAYMENT _____ RELATIONSHIP _____

PATIENT'S PRIMARY INSURANCE _____

PATIENT'S SECONDARY INSURANCE _____

IS THIS RELATED TO AN INJURY? ❑ Yes ❑ NO DATE OF INJURY _____

WHAT TYPE? JOB _____ AUTO _____ OTHER (PLEASE DESCRIBE) _____

NAME OF CARRIER _____

MAIL ADDRESS _____

CLAIM NUMBER _____ PHONE ( ) _____ EXT _____

CONTACT PERSON/ADJUSTER NAME _____

_____
RECEPTIONIST INITIALS

– OVER –

NOTICE TO ALL MEDICARE PATIENTS

❑ Medicare will only pay for services that it determines to be "reasonable and necessary" under section 1862(a)(1) of the Medicare law. If Medicare determines that a particular service, although it would otherwise be covered, is "not reasonable and necessary" under Medicare Program standards, Medicare will deny payment for that service.

I have been notified by this Medicare provider (Stockton MRI Medical Center, Inc.) that Medicare is likely to deny payment for the services listed below, for the denial reason listed below. IF MEDICARE DENIES PAYMENT, I AGREE TO BE PERSONALLY AND FULLY RESPONSIBLE FOR PAYMENT.

Procedure Description: #_____ _____ $_____
(CPT Code) *(Description)* *(Charge)*

Denial Reason:_____

1. MR Angiography – Medical Necessity and/or Not Covered
2. Chiropractor Referrals
3. Clinical indications that do not meet "reasonable and necessary" Medicare guidelines.
4. Other:_____

PATIENT OR RESPONSIBLE PARTY

❑ I hereby authorize any holder of medical information to release to my insurance company and /or agents or the Health Care Financing Administration and its agents, any information needed to determine the benefits or the benefits payable for related services.

I hereby authorize and request payment of medical benefits directly to Stockton MRI Medical Center, Inc., for services itemized on said claim.

I understand that I am responsible for the payment of any non-covered services, deductible, co-payments, or ineligibility upon determination by the insurance carrier.

I understand that I am responsible for payment of my account regardless of insurance coverage.

I do hereby authorize Stockton MRI Medical Center, Inc., to obtain any medical information and/or films concerning myself/other _____ that is pertinent to the
(State Patient Name and Relationship to Insured)
interpretation, evaluation and/or performance of any radiological procedure provided by Stockton MRI Medical Center, Inc.

X_____ Patient's Birth Date_____
(Patient or Responsible Party's Signature for a minor)

_____
(Please Print Name of Responsible Party and/or Insured's Name)

JAVAD JAMSHIDI. M.D.
JACK L. FUNAMURA. M.D.
FRANCIS P. ISIDORO. M.D.

STOCKTON MRI &
Molecular Imaging Medical Center, Inc.
2320 N. California St., Stockton, Ca. 95204

Tel: (209) 466-2000
(800) 270-2004
Fax: (209) 466-2600

CD/FILMS AND REPORT

We are releasing the Procedure Films/Report Of:

_____
(Patient Name)

_____
(Date of Service)

Please be aware that these records are the Patient/Physician Copy.
PLEASE DO NOT RETURN.

REPORT ONLY

At the request of our patient,_____ we are releasing this Procedure Report of_____dated _____(D.O.S.) to you. You must understand that the report is being released to you before your scheduled consult with the referring physician. Stockton MRI and Molecular Imaging Medical Center, Inc. urges you to keep your scheduled appointment.

You release Stockton MRI and Molecular Imaging Medical Center, Inc. of all liability and understand that the report is the interpretation of the Radiologist. All interpretations require correlation with clinical information that may not be available to the Radiologist. Front office and technical staff members are not available to discuss the findings of any medical report. Please direct all medical questions to your referring physician.

Signature of Patient/Guardian:_____

Date:_____

DOB:_____ ***MRN:***_____

Receptionist Initials:_____

JAVAD JAMSHIDI, M.D.
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BRIJ KAPADIA, M.D.
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HIPAA PATIENT CONSENT FORM

Our Notice of privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice prior to signing the Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree with this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information (PHI) about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosure we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

THE PATIENT UNDERSTANDS THAT:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Practices
- The Patient has the right to restrict the users of their information but the Practice does not have to agree to those restrictions.
- The Patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition receipt of treatment upon execution of this Consent.

This Consent was signed by: _____
Printed Name-Patient or Representative

_____ ___/___/___
Signature **Date**

(if other than patient) : _____

****

Do we have your permission to:

Leave a message on your answering machine at home? _____**YES** _____**NO**
Leave a message at your place of employment? _____**YES** _____**NO**
Discuss your medical condition with any member of your household? _____**YES** _____**NO**

If yes, whom:_____ **Relationship**_____

_____ _____
Patient Signature **Date**