CMI
Cooperative Magnetic Imaging

OUTPATIENT **Copay Amt and Type: _____**

Today's date:	Referring MD:		MRN#	
Patient's last name:	**First:**	**M.**	**(Maiden name):**	**Birth date:**
				/ /

Street address:	City, State	Zip Code	Age:	Sex:	
				❑ M	❑ F

Social Security no.:	Home Phone no.:	Cell no.:	Employer Name and Phone #:
	( )	( )	

Insurance Company(s):	Subscriber Name: *(if other than patient)*	*Circle One:* Spouse Parent Other: _____	Subscriber date of birth:

No Fault or Worker's Comp. case (Circle one)?	Emergency Contact Person:	Relationship:	Home phone no.:
Y or N :If yes, _____			( )

DEMOGRAPHICS UPDATED IN MRM AND AS400 _____INITIALS

- **RESPONSIBILITY FOR PAYMENT:** I understand that I am personally financially responsible to CMI and Practice Management Services (PMS) for charges I have incurred that are not covered by the assignment of benefits. Notwithstanding that this bill may be submitted for insurance, patient and his/her legal/authorized representative(s) acknowledge responsibility for the balance shown on the patient statement for services rendered.

- **LEGAL:** Patient agrees that, in the event proceedings are instituted to collect monies due for services, that the patient waives all jurisdiction and venue requirements, and that venue and jurisdiction hall lie in Oneida County, in either Utica City Court or Supreme Court, or in Herkimer County in the Little Falls County Court or Supreme Court, and if the patient is found liable, also agree to be responsible for reasonable legal fees and costs related to such proceedings.

- **PAYMENT @ TIME OF SERVICE (self-pay):** I understand that I am required to pay 100% of my charges at time of service, unless I have a medical insurance carrier in which CMI and PMS participates with and can show proof (current valid insurance card) of such coverage or have made other arrangements with CMI and Practice Management Services.

- **NO FAULT/WORKER'S COMPENSATION:** I understand that CMI and PMS will bill NYS No Fault Insurance on my behalf. I understand that CMI and PMS will bill Workers Compensation Insurance on my behalf. If I fail to prosecute this claim or it is denied or disallowed I agree to assume full financial responsibility.

- **PATIENT CONSENT:** As outlined in the Notice of Privacy Practices provided to me and pursuant to New York State Public Health Law, I understand and authorize Cooperative Magnetic Imaging to use, obtain, and release my personal health information and/or medical records, including obtaining medical records from other providers, hospitals or other health-related facilities, for any aspects of my treatment and care, payment of services, and for operational purposes.

- **NOTICE OF PRIVACY PRACTICES:** I acknowledge that I was offered a copy of the Cooperative Magnetic Imaging's Notice of Privacy Practices as mandated by the HIPAA Privacy Rule.

- **ADVANCED DIRECTIVES:** CMI acknowledges the patient's right an Advance Directive in accordance with NYS law. Please place your initials next to the appropriate statement(s) below.

  _____ I HAVE an Advance Directive in place: (if yes: check which) _____ Healthcare Proxy _____ Living Will _____ DNR

  _____ I DO NOT have an Advance Directive, but have been offered an informational packet for my review.

Date: _____ _____ _____

Signature of patient or parent/guardian CMI Witness

KT 3-19