RIDGELAND DIAGNOSTIC CENTER

PATIENT INFORMATION

LAST NAME: ____________________________________ **FIRST NAME:** ____________________________________

DATE OF BIRTH: ___________________ **SSN:** _______________________________ **MARTIAL STATUS: S / M / W / D**

ADDRESS: ____

CITY: ____________________________________ **STATE:** _____________ **ZIP:** ______________________

MAILING ADDRESS (IF DIFFERENT THAN ABOVE): ____

CITY: ____________________________________ **STATE:** _____________ **ZIP:** ______________________

HOME PHONE: ___________________________ **WORK PHONE:** _________________________ **CELL PHONE:** _________________________

EMPLOYER: ____ **PHONE:** _________________________

ADDRESS: ____

CITY: ____________________________________ **STATE:** _____________ **ZIP:** ______________________

EMERGENCY CONTACT: ____ **PHONE:** __________________

ARE YOU ALLERGC TO ANY MEDICATION AND OR LATEX? YES / NO

IF SO LIST ALLERGIES: ____

(FOR WOMEN IF YOU THINK YOU MAYBE PREGNANT PLEASE NOTIFY THE RECEPTIONIST OR TECHNOLOGIST BEFORE PROCEDURE)

ARE YOU PREGNANT? **YES / NO** ***LAST MENSTRUAL PERIOD***? ______________ ***IF LAST MENSTRUAL CYCLE IS MORE THAN A MONTH EXPLAIN***: ___________________

IS THIS A WORK INJURY: **YES / NO** **IF SO SUPERVISOR'S NAME:** ____

DO YOU HAVE LEGAL REPRESENTATION? (HAVE YOU HIRED AN ATTORNEY) **YES / NO**

ATTNORNEY'S NAME: ____ **PHONE:** _________________________

ADDRESS: ____**CITY:** __________________ **STATE:** __________**ZIP:** _______________

INSURANCE RELEASE OF INFORMATION AND ASSIGNMENT

I request that payment of authorized Medicare/Medicaid and any other commercial insurance benefits be made to Ridgeland Diagnostic Center. I authorize Ridgeland Diagnostic Center and/ or my attending physician to release any medical information necessary to file my insurance/personal injury claim. I authorize direct payment of benefits to Ridgeland Diagnostic Center. I understand that should my insurance declare any portion of my bill to be patient responsibility that I am financially responsible, if this account should be referred for collections, I am responsible for all collection expenses, including attorney fees.

PATIENT SIGNATURE: ____ ***DATE:*** ______________________

PERSON AUTHORIZED TO CONSENT: ____ ***RELATION TO PATIENT:*** ____

RIDGELAND DIAGNOSTIC CENTER

RADIOLOGIST BILLING CONTRACT

This facility contracts with certain specialist to render and directly bill for some services. These contractor's charges are not included in those of Ridgeland Diagnostic Center, Scott Medical Imaging or Goodman Medical Clinic.

All appropriate patient insurance will be provided to the independent contractor for this use only.

The services for which independent contractor may bill you are for the interpretation of the following radiology examinations:

1. *X-Ray*
2. *CT Scans*
3. *Ultrasounds*
4. *All Nuclear Scans*

The independent contractor is:

Mohammad Athar, M.D.
P.O. Box 14093
Jackson, MS. 39236

I authorize the independent contractor to release any medical information necessary to file my insurance claim. I understand that I may be separately billed for any of the above services, which have been requested by my physician. I understand that should my insurance declare any portion of my bill to be patient responsibility that I am financially responsible, if this account should be referred for collections, I am responsible for all collection expenses, including attorney fees.

PATIENT SIGNATURE: ____ ***DATE:*** ______________________

PERSON AUTHORIZED TO CONSENT: ____ ***RELATION TO PATIENT:*** ____

NOTICE OF PRIVACY PRACTICES

RIDGELAND DIAGNOSTIC CENTER AND OR SCOTT MEDICAL IMAGING

Under HIPPA

An individual has the following rights with regard to his or her PHI (Patient Health Information):

→ The Right To:
Consent or to authorize the use and disclosure of PHI.

→ The Right To:
Receive a copy of the practice's *NOTICE OF PRIVACY PRACTICES.*

→ The Right To:
Request restrictions on certain uses and disclosures of PHI.

→ The Right To:
Inspect and copy the PHI.

→ The Right To:
An accounting of the disclosures of PHI made by the covered entity for purposes other than TPO

→ The Right To:
Complain about alleged violations to the practice and DHHS.

RIDGELAND DIAGNOSTIC CENTER

ACKNOWLEDGEMENT OF RECEIPT
MEDICAL PRACTICE OF PRIVACY PRACTICES

I certify that I have received a copy of the *NOTICE OF PRIVACY PRACTICES*. The *NOTICE OF PRIVACY PRACTICES* describes the types of uses and disclosures of y protected health information that might occur in my treatment, payment of my bills or in the performance of Ridgeland Diagnostic Center and Scott Medical Imaging health care operations. The *NOTICE OF PRIVACY PRACTICES* also describes my rights and Ridgeland Diagnostic Center and Scott Medical Imaging's duties with respect to my protected health information. The *NOTICE OF PRIVACY PRACTICES is posted in the front lobby at* Ridgeland Diagnostic Center and on the website at www.scottmri.com

Ridgeland Diagnostic Center and Scott Medical Imaging reserves the right to change the privacy practices that are described in the *NOTICE OF PRIVACY PRACTICES.* I may obtain a revised *NOTICE OF PRIVACY PRACTICES by* calling the office and requesting a revised copy to be sent in the mail, getting a copy at the time of the appointment or accessing the website.

PATIENT SIGNATURE: ____ ***DATE:*** ______________________

PERSON AUTHORIZED TO CONSENT: ____ ***RELATION TO PATIENT:*** ____