ARIS DIAGNOSTIC MEDICAL PLLC

88-09 101 AVENUE
OZONE PARK, NY 11416
TEL: 718-577-5152
FAX: 718-835-7564

PATIENT INFORMATION

Name_____
Address_____
City/State/Zip_____
Home Phone #(___)_____
Business Phone#(___)_____
Date Of Birth_____
Age_____ Sex: Male/Female
Social Security____-_____-_____

ACCIDENT INFORMATION

Today's Date_____
Date Of Accident_____
Referred By_____
Dr Phone#(____)_____
Car Accident or Work Related
Driver Did You Work At The Time of The Accident?__
Is This Your First MRI After the Accident?___
X-Ray? Yes / No

EMPLOYER INFORMATION

Employer Name:_____
Address: _____
City:_____
State/ZIP Code:_____
Phone #: (____)_____
Fax #: (____)_____

ATTORNEY INFORMATION

Attorney's Name_____
Address_____
City_____
State/Zip/Code_____
Phone #(____)_____
Fax#(____)_____
Paralegal Name_____

SIGNATURE X_____

ARIS DIAGNOSTICS MEDICAL PLLC

88-09 101 AVENUE
OZONE PARK, NY 11416
TEL: 718-577-5152
FAX: 718-835-7564

Patient's Name_____Date_____

CIRCLE YES OR NO FOR THE FOLLOWING CONDITIONS

Mechanical Heart Valve	**(Yes) (No)**
Pacemaker	**(Yes) (No)**
Intro-Cranial or any Aneurysm Clips	**(Yes) (No)**
Metal Fragment in the eyes	**(Yes) (No)**
Epilepsy	**(Yes) (No)**
Metallic Prosthesis in the ears	**(Yes) (No)**
Hearing Aid (must be removed for the test)	**(Yes) (No)**
Greenfield Filter	**(Yes) (No)**
Any Shrapnel	**(Yes) (No)**
Any Previous Gun Shots	**(Yes) (No)**
Previous Bone Fracture Treated with	
Rods, Plates, Pins, Screws or Braces	**(Yes) (No)**
Body Weight greater than 280 pounds	**(Yes) (No)**
Prosthesis (dental must be removed for the test)	**(Yes) (No)**
Vascular Shunt	**(Yes) (No)**
Are you Pregnant	**(Yes) (No)**

SIGNATURE_____DATE_____

ARIS DIAGNOSTIC MEDICAL PLLC

88-09 101 AVENUE
OZONE PARK, NY 11416
TEL: 718-577-5152
FAX: 718-835-7564

ASSIGNMENT OF BENEFITS

PATIENT'S NAME: _____

IN CONSIDERATION OF SERVICES RENDERED OR TO BE RENDERED, I HEREBY ASSIGN TO THE PROVIDER OR SERVICES AND/OR HIS/HER ASSIGNEES SO MUCH OF MY FIRST PARTY WORKERS COMPENSATION INSURANCE BENEFITS AND RIGHTS, ATTENDANT THERE TO, AS SHALL DENY THE FULL AMOUNT OF THE BILL FOR SUCH SERVICES AND THE PROVIDER OR HIS ASSIGN MAY SECURE THE SAME IN MY NAME. I AM PERSONALLY RESPONSIBLE IF SAID SUM IS NOT COLLECTED.

_____ _____
DATE PATIENT'S SIGNATURE

AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS

KINDLY FURNISH TO MY INSURANCE COMPANY OR THEIR REPRESENTATIVES ALL INFORMATION YOU MAY HAVE REGARDING MY CONDITION WHILE UNDER YOUR TREATMENT OR OBSERVATION INCLUDING THE HISTORY OBTAINED, MRI AND PHYSICAL FINDINGS, DIAGNOSTIC AND PROGNOSIS YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION WITH THE WORKERS COMPENSATION BOARD.

ALSO THIS AUTHORIZATION OR PHOTOCOPY THEREOF, WILL AUTHORIZE MY INSURANCE COMPANY AND DOCTORS OFFICE TO FURNISH ALL INFORMATION THEY MAY HAVE REGARDING MY CONDITION WHILE UNDER THEIR OBSERVATION AND REVIEW INCLUDING THE HISTORY OBTAINED AND PHYSICAL FINDINGS, DIAGNOSIS AND PROGNOSIS.

_____ _____
DATE PATIENT'S SIGNATURE

Patient Name:_____ Date of Birth:____/____/____

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in details the uses and disclosures of my protected health information that may be made by this practice of my individual rights and practice's legal duties with respect to my protected health information. The notice includes

- A statement that this practice is required by law to maintain the privacy of the protected health information.
- A statement that this practice is required to abide by the terms of this notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and health care operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclosure protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
  *The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that retaliatory actions will be used against me in the event of such complaint.
  *The right to request restriction on certain uses and disclosures of my protected health information and that this practice is not required to agree to a requested restriction.
  *The right to receive confidential communications of protected health information.
  *The right to inspect and copy protected health information.
  *The right to amend protected information.
  *The right to receive an accounting disclosures of protected health information.
  *The right to obtain a paper copy of the Notice Of Privacy from this office upon request.

This practice reserves the rights to change the term of its Notice of Privacy Practices and to make new provisions elective for all protected health information that it maintains I understand that I can obtain the practices current Notice if Privacy Practices upon request.

Signature X_____Date:_____

Relationship to patient (if signed by personal representative of patients)_____

DOS	Patient’s Signature