OPEN MRI of S.A.N.S.C.

CONFIDENTIAL PATIENT INFORMATION SHEET

DATE: _____

PRIMARY/REFERRING DOCTOR: _____ PHONE #: _____

IS YOUR VISIT RELATED TO AN INJURY OR ACCIDENT? _____ YES _____ NO

IF YES, WHAT KIND OF ACCIDENT OR INJURY? _____ AUTO _____WORKER'S COMPENSATION

PATIENT INFORMATION

LAST NAME:_____ FIRST NAME:_____ MI:_____

RESPONISIBLE PARTY (IF A MINOR):_____

ADDRESS:_____ APT. #_____

CITY:_____ STATE:_____ ZIP:_____

HOME PHONE#: _____ WORK PHONE #:_____

DATE OF BIRTH:_____ SEX: ( ) M ( )F SOCIAL SECURITY #:_____

( ) SINGLE ( ) MARRIED ( ) WIDOW ( ) SEPARATED ( ) DIVORCED ( ) OTHER _____

EMPLOYER INFORMATION

EMPLOYER NAME:_____ OCCUPATION:_____

EMPLOYER ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

PRIMARY INSURANCE

INSURANCE COMPANY: _____

ADDRESS: _____

_____ PHONE #:_____

***POLICY HOLDER*:** _____ ***DATE OF BIRTH*:**_____

POLICY #:_____

RELATIONSHIP TO INSURED: ( ) SELF ( )SPOUSE ( ) CHILD ( ) OTHER

SECONDARY INSURANCE

INSURANCE COMPANY: _____

ADDRESS: _____

_____ PHONE #:_____

POLICY HOLDER: _____ DATE OF BIRTH:_____

POLICY #:_____

RELATIONSHIP TO INSURED: ( ) SELF ( )SPOUSE ( ) CHILD ( ) OTHER

EMERGENCY CONTACT:_____

RELATIONSHIP: _____

Release of Information

I hereby authorize South Atlanta Neurology and Spine Clinic to release any information concerning my treatment to any insurance company for the purpose of determining eligibility for payment of insurance benefits. This included information regarding treatment for substance abuse or HIV.

I authorize South Atlanta Neurology and Spine Clinic to disclose protected health information (PHI) about me to the following person/people:

Name:_____ **Name:_____**
Relationship:_____ **Relationship:_____**

This authorization will permit South Atlanta Neurology and Spine Clinic to release any and all information pertaining to my health and well-being. **This authorization will expire on :_____.**
(There must be a date of expiration/event, whether it is 10-100 years, divorce, death, etc.)

I understand that when my PHI is used or disclosed pursuant to this authorization, it may be subject to disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to: South Atlanta Neurology and Spine Clinic, 518 Eagles Landing Parkway, Stockbridge, GA 30281.

_____ _____/_____/_____

Signature of Patient or Legal Guardian Date