180 NORTH DEAN STREET • ENGLEWOOD, NJ 07631
TEL: 201.568.4242 • FAX: 201.568.1298
WWW.BERGENIMAGINGCENTER.COM
CHRISTOPHER L. PETTI, MD
ELIZABETH O'CONNELL MAZZEI, MD
ACCREDITED BY THE AMERICAN COLLEGE OF RADIOLOGY

Name______________________________

Street Address______________________________

City______________________________

(needed if submitting claim electronically)

State______ **Zip Code**______________ **Social Security Number**______________

Home #______________ **Work #**______________

Cell #______________ **Date of Birth**______________

Email Address:______________________________

Referring Physician(s):______________________________

____

Employer Name______________________________

Employer Address______________________________

City______________________________

State______ **Zip Code**______________ **Employer Phone Number**______________

Race (Optional):______________________________

Nationality (Optional):______________________________

If you weren't referred to us by a physician, how did you hear about us?

Internet Search: Google ☐ Yahoo ☐ Bing ☐

Physician Referral Website: Superdoctors.com ☐ Vitals.com ☐ Healthgrades.com ☐

Ucomparehealth.com ☐ Ratemds.com ☐

My insurance carriers' website. If so, please specify______________________________.

Other______________________________

Signature______________________________ Date______________

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Primary Insurance Carrier______________________________ **ID#** ________________________

Guarantor Name & Date of Birth____

Secondary Insurance Carrier____________________________ **ID#** ________________________

Guarantor Name & Date of Birth____

Financial Agreement between ________________________________ **(please print your full name)**
and Bergen Imaging Center, PA (B.I.C.). It is my responsibility to provide accurate and valid insurance information. In the event the information provided is incorrect, I accept full financial responsibility.

__________ Since I have been informed that B.I.C. does not participate with my particular insurance plan or since I do not have medical insurance to cover the cost of service, I agree to pay today by;

☐ **CASH** ☐ **CHECK** ☐ **CREDIT CARD**

__________ Since B.I.C. participates with my insurance carrier, I expect it to pay B.I.C. directly for this service. If a referral form or pre-authorization is required by my insurance carrrier, I understand it is my responsibility to provide you with these documents. If the claim is denied by my carrier, I understand I will be responsible for the outstanding balance.

All balances are due upon 30 days of receipt. I understand that I will be charged a billing surcharge on balances that have not been paid within this timeframe

HIPPA Compliancy

I have been informed that a copy of Bergen/Digital Imaging Center's Notice of Privacy Practices is available to me upon request.

Medical Records

Under the Mammography Quality Standards Act, all FDA accredited Mammography facilities are required to obtain pathology in which biopsy was recommended by the radiologist. As a result of this federal law, we need to obtain a copy of your pathology and/or surgical reports or other pertinent medial records if a biopsy was not performed by this facility. By signing this release form, I authorize the release of my Protected Health Information (PHI) to Bergen Imaging Center, P.A./ Digital Imaging Center.

Cancellation Policy

In consideration of other patients, we have a 24 hour cancellation policy. There will be a charge of $25.00 for no shows or for cancellations without proper notice. This charge will not be covered by your insurance carrier and will have to be paid by you personally. By signing this form, you agree to this policy.

I understand and accept the terms described above

Signature____ Date________________________