BERGEN
IMAGING CENTER, P.A.
WOMEN'S IMAGING SPECIALISTS OF ENGLEWOOD

180 NORTH DEAN STREET • ENGLEWOOD, NJ 07631
TEL: 201.568.4242 • FAX: 201.568.1298
WWW.BERGENIMAGINGCENTER.COM
CHRISTOPHER L. PETTI, 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# _____

Policy Holder Name & Date of Birth _____ID# _____

Secondary Insurance Carrier _____ ID#_____

Policy Holder Name & Date of Birth _____ID# _____

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 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 carrier, 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 of $25 on balances that have not been paid within this timeframe.**

_____ Since I have been informed that B.I.C. does not participate with my 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

HIPPA Compliancy

I have been informed that a copy of Bergen/Digital Imaging Centers 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 medical 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 _____