Ramapo Diagnostic Imaging
Ramapo Radiology Associates, P.C.
RAMAPO DIAGNOSTIC IMAGING
11 NORTH AIRMONT ROAD
SUFFERN, NY 10901
(877) 437-XRAY (9729)
Phone (845) 357-7245
Fax (845) 357-7907
www.ramaporadiology.com

PET/CT Imaging of Ramapo Radiology
PET/CT IMAGING OF RAMAPO RADIOLOGY
POMONA PROFESSIONAL PLAZA, 972 ROUTE 45
POMONA, NY 10970
(877) 437-XRAY (9729)
Phone (845) 354-8909
Fax (845) 354-8910
www.petctimagingoframaporadiology.com

Orange Radiology Associates, P.C.
MRI OF NEWBURGH
320 ROBINSON AVENUE
NEWBURGH, NY 12550
(877) 437-XRAY (9729)
Phone (845) 565-3664
Fax (845) 565-3617

MRI OF ORANGE
505 ROUTE 208
MONROE, NY 10950
(877) 437-XRAY (9729)
Phone (845) 783-3444
Fax (845) 783-9561
www.orangreradiology.com

Patient Last Name: _____ First Name: _____ Middle Initial: _____

Patient Street Address: _____ Apt. #: _____

City: _____ State: _____ Zip: _____

Home Phone #: _____ Cell #: _____ Male/Female (Circle One) Date of Birth: _____

E-Mail Address: _____

Primary Insurance: _____ ID#: _____

Secondary Insurance: _____ ID#: _____

Insurance Holder/Guarantor: _____
(Last Name) (First Name) (Initial)

Insured's Street Address: _____ Apt. #: _____

City: _____ State: _____ Zip: _____

Insured's Date of Birth: _____ Male/Female (Circle One) Insured's Telephone #: _____ SS#: _____

ASSIGNMENT OF BENEFITS

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE/OTHER INSURANCE CARRIER BE MADE ON MY BEHALF TO ORANGE RADIOLOGY/MRI OF ORANGE FOR SERVICES FURNISHED TO ME BY THE PROVIDER. I ALSO AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NEEDED TO DETERMINE THESE BENEFITS PAYABLE FOR RELATED SERVICES.

Patient/Guardian Signature: _____ Date: _____
(Must be 18 years of age or older or signed by guardian)

RAMAPO PRACTICE MANAGEMENT PRIVACY NOTICE

Acknowledgement of Review of Privacy Notice

I acknowledge that I have reviewed the Privacy Notice.

Patient/Guardian/Personal Representative Signature: _____ Date: _____

If Personal Representative's signature appears above, please describe the relationship to the patient:

_____

PATIENT AUTHORIZATION

Should you need your records and were not available to pick them up yourself, please list who would be authorized to do so. I, _____ authorize Ramapo Practice Management, LLC to release information regarding my care to the following individual(s):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Specific information being discussed: _____

Patient Signature: _____ Date: _____