ZILKHA RADIOLOGY

Long Island Magnetic Resonance Imaging, P.C.
Long Island Medical Imaging, P.C.
Long Island Medical Diagnostic Imaging, P.C.

369 EAST MAIN STREET; SUITE 18
EAST ISLIP, NY 11730
(631) 277-1600 /FAX (631) 277-1638

1161 MONTAUK HIGHWAY
WEST ISLIP, NY 11795
(631) 669-1717 /FAX (631) 669-2227

WORKERS COMPENSATION OR NOFAULT

Today's Date ____________ Patient Name ____

Insurance Carrier _______________________________________ Date of Accident/Injury ________________

Insurance Co. Address ____

Policy Number _______________________________ Claim Number __________________________________

Policy Holder ______________________________________ Relationship to You _______________________

Claims Representative & Number ____

Lawyer Name & Number ____

Description of Accident ____

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NO-FAULT PATIENTS ONLY: No-fault regulations require that my bill be submitted by the treating office within 45 days from the date of service (today). Due to this regulation, I understand that if I do not supply Long Island Magnetic Resonance Imaging, P.C., Long Island Medical Imaging, P.C., and Long Island Medical Diagnostic Imaging, P.C. with the correct insurance carrier information in a timely manner, I am responsible for payment.

Patient/Guardian Signature ____ Date ______________

NO-FAULT PATIENTS ONLY:

Please List all Doctors/Facilities that you have received treatment related to your injury:

Name ____ Phone Number ________________

Name ____ Phone Number ________________

Name ____ Phone Number ________________

Name ____ Phone Number ________________

Name ____ Phone Number ________________

Hospital Name & Location ____

Authorization to Obtain Medical Records: I authorize the release of any and all medical records to Long Island Magnetic Resonance Imaging, P.C., Long Island Medical Imaging, P.C., and Long Island Medical Diagnostic Imaging, P.C. in regards to my automobile accident listed above.

Patient/Guardian Signature ____ Date ______________