Nassau Open MRI, P.C.

PATIENT'S INTERVIEW SCREENING FORM

Your doctor has scheduled you for a Magnetic Resonance Imaging (MRI) scan. The machine looks like a CT scanner and utilizes a magnetic field and radio frequency waves to obtain images. There are no known biohazards.

MRI forms pictures of the body by positioning it within a magnetic field. Radio signals are transmitted into the tissues and a computer records the "echos" which return. The pattern of the echos is made into a picture of the body's internal structures.

Because of the presence of a magnetic field, it is important we are aware of any metallic objects that may have been surgically implanted into your body. Therefore, an accurate surgical and medical history is needed. Also, magnetically attracted objects worn must be removed before entering the MRI exam suite.

We would like to know if you have any of the items listed below. Please check the appropriate responses.

YES	NO	
___	___	Cardiac Pacemaker
___	___	Neurostimulator (TENS unit)
___	___	Other implanted electrodes, pumps or electronic devices
___	___	Diabetic Insulin Pump
___	___	Brain Aneurysm Clip (History of brain surgery)
___	___	Shunt
___	___	Seizures
___	___	heart Bypass Surgery
___	___	Heart Valve Surgery
___	___	Cardiac Arrhythmias
___	___	Other Heart Surgeries
___	___	Abdominal Aneurysm Clip
___	___	Other Abdominal Surgeries
___	___	Eye Prosthesis
___	___	Hearing Aid
___	___	Dentures
___	___	Middle Ear Prosthesis
___	___	Metal Mesh
___	___	Wire Sutures
___	___	War Injury or Gunshot Wound
___	___	Other known possible metal fragments in the head, eye or body (Ex: welders, machinists, sheet metal workers, etc.)
___	___	IUD
___	___	Penile Prosthesis
___	___	Joint/Limb Replacement
___	___	Fractured bones treated with metal rods, metal plates, pins, screws, nails or clips
___	___	Harrington Rods
___	___	Prosthesis (Ex: artificial limbs)
___	___	Permanent Eye Liner
___	___	Wig, Toupee, etc.
___	___	Makeup with Metallic Fragments
___	___	Known or Possible Pregnancy
___	___	Nervousness in confined spaces (Claustrophobia)
___	___	Other: _____

I have read the above information and answered the preceding questions to the best of my knowledge. I hereby give my consent to have a Magnetic Resonance Image Scan. Any questions I may have had were directed to my doctor or the MRI staff.

Patient Name _____ Body Part _____

Dr. Name _____ Date of Birth _____ Weight _____

Patient Signature _____ Date _____ NF WC PVT LIEN

STAFF INITIAL _____

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
APPLICATION FOR MOTOR VEHICLE NO-FAULT BENEFITS

NAME AND ADDRESS OF INSURER *	NAME, ADDRESS, AND PHONE NUMBER OF INSURER'S CLAIMS REPRESENTATIVE*

DATE	POLICYHOLDER	POLICY NUMBER	DATE OF ACCIDENT	CLAIM NUMBER

TO ENABLE US TO DETERMINE IF YOUR ARE ENTITLED TO BENEFITS UNDER THE NEW YORK NO-FAULT LAW, PLEASE COMPLETE THIS FORM AND RETURN IT PROMPTLY.

IMPORTANT: 1. TO BE ELIGIBLE FOR BENEFITS YOU MUST COMPLETE AND SIGN THIS APPLICATION.
2. YOU MUST SIGN ANY ATTACHED AUTHORIZATION(S).
3. RETURN PROMPTLY WITH COPIES OF ANY BILLS YOU HAVE RECEIVED TO DATE.

NAME AND ADDRESS OF APPLICANT*

1. YOUR NAME	2. PHONE NOS. HOME	BUSINESS

3. YOUR ADDRESS (NO., STREET, CITY OR TOWN AND ZIP CODE)	4. DATE OF BIRTH	5. SOCIAL SECURITY NO.

6. DATE AND TIME OF ACCIDENT A.M. P.M.	7. PLACE OF ACCIDENT (STREET), CITY OR TOWN AND STATE

8. BRIEF DESCRIPTION OF ACCIDENT

9. DESCRIBE YOUR INJURY

10. IDENTITY OF VEHICLE YOU OCCUPIED OR OPERATED AT THE TIME OF THE ACCIDENT:

OWNER'S NAME MAKE YEAR

THIS VEHICLE WAS: ☐ A BUS OR SCHOOL BUS, ☐ OR A MOTORCYCLE ☐ A TRUCK, ☐ AN AUTOMOBILE,

	YES	NO
11. WERE YOU THE DRIVER OF THE MOTOR VEHICLE?	☐	☐
WERE YOU A PASSENGER IN THE MOTOR VEHICLE?	☐	☐
WERE YOU A PEDESTRIAN?	☐	☐
WERE YOU A MEMBER OF OUR POLICYHOLDER'S HOUSEHOLD?	☐	☐
DO YOU OR A RELATIVE WITH WHOM YOU RESIDE OWN A MOTOR VEHICLE?	☐	☐

CONTINUATION ON NEXT PAGE

APPLICATION FOR MOTOR VEHICLE NO-FAULT BENEFITS - - PAGE TWO

12. WERE YOU TREATED BY A DOCTOR(S) OR OTHER PERSON(S) FURNISHING HEALTH SERVICES?

YES ☐ NO ☐

IF YES, NAME AND ADDRESS OF SUCH DOCTOR(S) OR PERSON(S):

13. IF YOUR WERE TREATED AT A HOSPITAL(S), WERE YOU AN

OUT-PATIENT? ☐ IN-PATIENT? ☐

DATE OF ADMISSION: _____

HOSPITAL'S NAME AND ADDRESS: _____

14. AMOUNT OF HEALTH BILLS TO DATE:	15. WILL YOU HAVE MORE HEALTH TREATMENT(S)?	16. AT THE TIME OF YOUR ACCIDENT WERE YOU IN THE COURSE OF YOUR EMPLOYMENT?
$ _____	YES ☐ NO ☐	YES ☐ NO ☐

17. DID YOU LOSE TIME FROM WORK?	DATE ABSENCE FROM WORK BEGAN:	HAVE YOU RETURNED TO WORK?
YES ☐ NO ☐		YES ☐ NO ☐

IF YES, DATE RETURNED TO WORK:	AMOUNT OF TIME LOST FROM WORK:
_____	_____

18. WHAT ARE YOUR GROSS AVERAGE WEEKLY EARNINGS?	NUMBER OF DAYS YOU WORK PER WEEK:	NUMBER OF HOURS YOU WORK PER DAY:

19. WERE YOU RECEIVING UNEMPLOYMENT BENEFITS AT THE TIME OF THE ACCIDENT?

YES ☐ NO ☐

20. LIST NAMES AND ADDRESS OF YOUR EMPLOYER AND OTHER EMPLOYERS FOR ONE YEAR PRIOR TO ACCIDENT DATE AND GIVE OCCUPATION AND DATES OF EMPLOYMENT:

EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO
EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO
EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO

21. AS A RESULT OF YOUR INJURY HAVE YOU HAD ANY OTHER EXPENSES?

YES ☐ NO ☐

IF YES, ATTACH EXPLANATION AND AMOUNTS OF SUCH EXPENSES.

22. DUE TO THIS ACCIDENT HAVE YOU RECEIVED OR ARE YOU ELIGIBLE FOR PAYMENTS UNDER ANY OF THE FOLLOWING:

	YES	NO
NEW YORK STATE DISABILITY?	☐	☐
WORKERS' COMPENSATION?	☐	☐

CONTINUATION ON NEXT PAGE

THE APPLICANT AUTHORIZES THE INSURER TO SUBMIT ANY AND ALL OF THESE FORMS TO ANOTHER PARTY OR INSURER IF SUCH IS NECESSARY TO PERFECT ITS RIGHTS OF RECOVERY PROVIDED FOR UNDER THE NO-FAULT LAW.

THIS FORM IS SUBSCRIBED AND AFFIRMED BY THE APPLICANT AS TRUE UNDER THE PENALTIES OF PERJURY

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

SIGNATURE _____ DATE _____

DO NOT DETACH

AUTHORIZATION FOR RELEASE OF WORK AND OTHER LOSS INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY THEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY WAGES, SALARY OR OTHER LOSS WHILE EMPLOYED BY YOU. YOUR ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE NEW YORK COMPREHENSIVE MOTOR VEHICLE INSURANCE REPARATIONS ACT (NO-FAULT LAW).

NAME (PRINT OR TYPE) _____ SOCIAL SECURITY NO. _____

SIGNATURE _____ DATE _____

DO NOT DETACH

AUTHORIZATION FOR RELEASE OF HEALTH SERVICE OR TREATMENT INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY THEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY CONDITION WHILE UNDER YOUR OBSERVATION OR TREATMENT, INCLUDING THE HISTORY OBTAINED, X-RAYS AND PHYSICAL FINDINGS, DIAGNOSIS AND PROGNOSIS. YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE NEW YORK COMPREHENSIVE MOTOR VEHICLE INSURANCE REPARATIONS ACT (NO-FAULT LAW).

NAME (PRINT OR TYPE) _____

SIGNATURE _____ DATE _____

(IF THE APPLICANT IS A MINOR, PARENT OR GUARDIAN SHALL SIGN AND INDICATE CAPACITY AND RELATIONSHIP).

*LANGUAGE TO BE FILLED IN BY INSURER OR SELF-INSURER.

Nassau Open MRI, P.C.
TEL: 718-815-2002 FAX: 718-815-3003
Patient Information Sheet
** All Requested Information **MUST** be Completed **

Patient's Name:
Nombre del paciente:
Last: _____ **Middle:** _____ **First:** _____

Patient Maiden Name: (if applicable) _____
Apellido de soltera del paciente:

Patient's Address: _____ ***Apt #:*** _____
Dirección del paciente: **El apartamento**

_____

Patient's Telephone: _____ **Cell Phone:** _____
Numero de teléfono Telefono Celular

Date of Birth: _____ **Date of Accident:** _____
Fecha de nacimiento: Fecha de accidente:

Insurance Company: _____
Compañía de seguro:

Policy & Claim Number: _____
Numero de poliza:

Referring Doctors Name: _____
Doctor que lo refirió:

Referring Doctor's Tel: _____
Telefono del doctor:

Social Security # _____
Numero de Seguro Social

Attorney's Name: _____
Nombre del abogado:

Attorney's Tel: _____ *Attorney's Fax:* _____
Teléfono del abogado: Numero de facsimile:

** **Favor de completar toda la información requerida** **

STAFF INITIAL _____

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
ASSIGNMENT OF BENEFITS FORM

(FOR INCIDENTS OCCURRING ON OR AND AFTER 311102)

I, _____ ("Assignor") hereby assign to *Nassau Open MRI, P. C.* "(Assignee")
(Print Patient's Name) all rights, privileges and remedies to payment for health care services provided by assignee to which I am entitled under Article 51 (the No Fault Statute) of the Insurance Law.

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained due to the motor vehicle accident which occurred on _____ notwithstanding any other agreement to the contrary.
(Print accident date)

This agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack of coverage and/or violation of a policy condition due to the actions or conduct of the assignor.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

_____
(Print Name of Patient)

X _____
(Signature of Patient)

_____

X _____
(Date of Patient Signature)

_____

_____
(Address of Patient)

X Dr. Eliezer Offenbacher, MD
(Print Name of Provider)

x _____
(Signature of Provider)

5th Ave Open MRI,PC
8304 5th Avenue
Brooklyn, New York
11209

_____
(Date of signature)

NYS FORM NF-AOB (3-2004)

STAFF INITIAL _____

ASSIGNMENT, LIEN, AUTHORIZATION AND SIGNATURE

* _____ * _____

Patient's Name | Insured's Name

* _____ * _____

Insurance Company | Claim Number

I hereby authorize and direct you, my insurance company and/or my attorney, to pay directly to *Nassau Open MRI, P.C.* such sums as may be due and owing *Nassau Open MRI, P.C.* for services rendered me or my family members, both by reason of accident or illness, and by reason of any other bills that are due *Nassau Open MRI, P.C.* and to withhold such sums from any disability benefits obligated to reimburse me or from any settlement judgment or verdict on my behalf as may be necessary to adequately protect *Nassau Open MRI, P.C.* This document is to act as an assignment of my rights and benefits to the extent of the services provided by *Nassau Open MRI, P.C.* In the event that a direct assignment of my rights and benefits are not permitted or accepted, this assignment shall be considered a direct assignment of any proceeds or payments to be paid to me.

I hereby sign and give a lien to *Nassau Open MRI, P.C.* against any and all insurance benefits named herein and any and all proceeds of settlement judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated.

In the event that my insurance company, which is obligated to make payments to me, *Nassau Open MRI, P.C.* upon the charges made by *Nassau Open MRI, P.C.* refuses to make such payments either upon the demand of *Nassau Open MRI, P.C.* or me, I hereby assign and transfer to *Nassau Open MRI, P.C.* any and all causes of action that I might have or that might exist in my favor against such insurance company and authorized *Nassau Open, P.C.*to prosecute said cause(s) of action either in my name or in name. I further authorize *Nassau Open, P.C.*to compromise, settle, or otherwise resolve said claim(s) or cause(s) of action as they see fit.

I understand that I remain personally responsible for the total amounts due to the medical provider for any and all services rendered me by *Nassau Open MRI, P.C.* I understand and agree that if my Workmen's Compensation or No-Fault claim or Lien or Private Insurance claim is denied, or has a balance due, because I failed to comply with the conditions set forth by those agencies (i.e., returning paperwork, body part not accepted, appearing for hearings, EUO's, etc.), or my medical bills exceed the applicable limit or my deductible/co-payment is applied to any payment, then I accept responsibility for the full balance due for any and all services rendered me or my family members. I further understand and agree that this assignment does not constitute any consideration for *Nassau Open MRI, P.C.* to await payments that *Nassau Open MRI, P.C.* as its option, may demand from me immediately upon rendering services.

I hereby authorize *Nassau Open MRI, P.C.* to release any information pertinent to my case to any insurance company or attorney to facilitate collection under this assignment. I agree that *Nassau Open MRI, P.C.* be given special Power of Attorney to endorse/sign my name on any and all checks and claim forms for payment of my bills.

This document shall stand as my signature on file.

This assignment is to become effective as of the day indicated below and shall remain effective as long as services are being rendered to me/or my family members and/or until all Third-Party monies owed to *Nassau Open MRI, P.C.* for services rendered are paid in full.

A photocopy of this assignment shall be considered as effective and valid as the original.

I attest that the terms of the assignment have been satisfactorily explained to me by the staff at *Nassau Open MRI, P.C.* prior to signing this document. I further attest that I have read and understand the Notice of Alternative Treatment posed at the bottom of this document.

* _____ * _____

Patient's Signature | Date

Notice of Alternative Treatment

Our patients are advised that they have the option of seeking treatment at the office/facility of another *Nassau Open MRI, P.C. not affiliated with Nassau Open MRI, P.C.* Our patients may have any procedure, test or treatment recommended by any doctor in this office performed in the office/facility of another medical provider. A listing of alternative health care services and/or *Nassau Open MRI, P.C.* may be found in the classified section of the telephone directory under appropriate heading or upon the patient's request; the staff of *Nassau Open MRI, P.C.* will do their best to provide information about other medical providers where appropriate and/or similar services may be obtained.

STAFF INITIAL _____

Nassau Open MRI

1570 Old Country Road · Westbury, New York 11590
tel: 516-OPEN-MRI · fax: 516-385-6488

PREGNANCY DENIAL FORM

TO ALL WOMAN OF CHILD BEARING AGE (AGES 12 AND UP):

PLEASE READ THE STATEMENT BELOW. IF TRUE, PLEASE SIGN AND DATE. THANK YOU.

To Whom It May Concern:

I, _____, hereby state that there is no possibility that I am pregnant at this time.

_____
SIGNATURE

_____
DATE

STAFF INITIAL _____

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
Nassau Open MRI, P.C. 1570 Old Country Rd. - Westbury, NY 11590

8. Name and address of person(s) or category of person to whom this information will be sent:

9(a). Specific information to be released:

- ☐ Medical Record from (insert date) _____ to (insert date) _____
- ☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ☐ Other: _____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ (Initials) I authorize _____ (Name of individual health care provider) to discuss my health information with my attorney, or a governmental agency, listed here:

_____ (Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information: ☐ At request of individual ☐ Other:	11. Date or event on which this authorization will expire:
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____

Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

Instructions for the Use of the HIPAA-compliant Authorization Form to Release Health Information Needed for Litigation

This form is the product of a collaborative process between the New York State Office of Court Administration, representatives of the medical provider community in New York, and the bench and bar, designed to produce a standard official form that complies with the privacy requirements of the federal Health Insurance Portability and Accountability Act ("HIPAA") and its implementing regulations, to be used to authorize the release of health information needed for litigation in New York State courts. It can, however, be used more broadly than this and be used before litigation has been commenced, or whenever counsel would find it useful.

The goal was to produce a standard HIPAA-compliant official form to obviate the current disputes which often take place as to whether health information requests made in the course of litigation meet the requirements of the HIPAA Privacy Rule. It should be noted, though, that the form is optional. This form may be filled out on line and downloaded to be signed by hand, or downloaded and filled out entirely on paper.

When filing out Item 11, which requests the date or event when the authorization will expire, the person filling out the form may designate an event such as "at the conclusion of my court case" or provide a specific date amount of time, such as "3 years from this date".

If a patient seeks to authorize the release of his or her entire medical record, but only from a certain date, the first two boxes in section 9(a) should both be checked, and the relevant date inserted on the first line containing the first box.

Nassau Open MRI
1570 Old Country Road · Westbury, New York 11590
tel: 516-OPEN-MRI · fax: 516-385-6488

Video Surveillance Policy–Patient Acknowledgement, Consent and Release

Please be informed this entire property, located at Nassau Open MRI, P.C., (the "Property"), is under ***video surveillance 24 hours a day***. For security purposes ***you are being recorded*** from the time you enter the Property until the time you leave the property.

Video surveillance systems are in use throughout the property, including, but not limited to, the waiting room, reception, elevators, hallways, MRI Room, X-Ray Room and all general common spaces. The video surveillance system ***is not*** in use in areas where there is a reasonable expectation of privacy to disrobe, such as a restroom, dressing area or locker room. This is a non-cloud based surveillance system. The video surveillance system is recorded in the administrative offices of the Practice. The DVR is located on-site and is rewritten every 30 days.

The ***primary purpose*** of the Video Surveillance system is to allow for the after-the-fact-investigation or crimes committed against Nassau Open MRI, P.C. (the "Practice"). In addition, the video surveillance system, including video recordings, may be used and stored as required by the Practice, in its sole discretion including, but not limited to, for the purpose of assisting in the investigation of certain types of safety violations, as a tool of patient supervision, employee diligence, and/or documentation. However, the Practice shall only use and store recorded videos in compliance with the Health Insurance Portability and Accountability Act and the Health Information Technology for Economic and Clinical Health Act.

I hereby give my consent to the video surveillance, including the storage and use of video recordings, as the Practice deems fit in its sole discretion.

_____	_____	_____
(Signature)	(Print Name)	(Date)

STAFF INITIAL _____