ULTRASOUND NEW PATIENT

MRI Now

Patient Name	Age	Gender M F	Date
Mailing Address	Marital Status S M D W	SSN	Home Number
City State Zip	Date Of Birth	Weight	Cell Number
Contact Person	Relationship		Phone Number
Referring Physician			

Guarantor (if different from above) **Policy Holder (if different from above)**

Employer	Name	DOB:
Address	Employer	
Phone	Address	
Primary Insurance	Phone	SSN
Secondary Insurance	Relationship to Patient	

Medical Review		
Y N IUD/ Pessary/ Diaphragm	Y N Body Piercings	Y N If female, are you pregnant
Y N History of cancer	Y N Metal rods, pins, screws, etc.	Date of last menstrual cycle
Y N History of kidney Problems		Y N If female are you breastfeeding?

Previous MRI, CT, XRAY on same area Y N	Surgery on scanned area?
When/ Where was it done?	When/ Where?

ARE YOU HERE BECAUSE OF A WORK RELATED INJURY, AUTO INJURY, SCHOOL INJURY OR PERSONAL INJURY?

YES____ NO_____

ASSIGNMENT OF INSURANCE BENEFITS

_____I authorize payment of medical benefits directly to this facility,
initial **MRI Now**. I understand that any unpaid balance will be my responsibility.

ATTENTION PATIENTS WITH MEDICAREINSURANCE.

Have you made and changes to your Medicare coverage? YES NO
NO
If so, please explain here: _____

_____

Are you currently in a skilled nursing facility?

NO YES If yes fill out below.
Name of Facility_____
Phone # _____

IF YOU ARE IN A SKILLED NURSING FACILITY PLEASE NOTIFY THE RECEPTIONIST

I attest that the information above is correct to the best of my knowledge. I give consent to the examination ordered by my physician. According to the information above, I acknowledge that I have given this facility the right to file to my insurance for payment of services rendered and I agree to pay any balance remaining on the account after my insurance has paid or denied payment. I understand I must pay any deductible and /or coinsurance at the time of service, that the quote for deductible and/or coinsurance is only an estimate, and that a prior authorization from the insurance is not a guarantee of their payment of my claim. I acknowledge that when insurance is involved, MRI Now is contractually obligated to collect co- payments, co-insurance, and deductible as outlined by my insurance carrier. My insurance information will be given to the radiologist for payment of services rendered for the interpretation of the requested study. I authorize release of my medical information to and from physicians, nursing facilities and/or other health care agencies to which I may be referred or transferred. I also understand that a $35.00 service fee will be charged for all returned checks. r agree, in addition to the amount owed for my current visit, I will be responsible for the fee charged by a collection agency for cost of collections if such action becomes necessary**. ***This is a notification that certain services that are deemed necessary by your physician may not be reimbursed by your insurance company, including Medicare, I also acknowledge the Notice of Privacy Practice available in the office*****

_____

Patient Signature Date

AUTHORJZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

HIPAA Authorization Form

The report containing your results will automatically be sent to your ordering physician following your exam. MRI Now cannot release any information to any individual other than you unless listed below. This includes picking up reports and films/CD' s. ID will be required for pickup. Please list any family member or friend you might send in for pickup of these items. It is not necessary to list your ordering doctor.

I,_____authorize MRI Now (healthcare facility} to release my medical information to the following parties listed below until I revoke this release in writing.

Please print:

Name and relationship_____

Name andrelationship_____

Name andrelationship_____

Acknowledgement of Receipt of Notice of Privacy Practices

MRI Now

reserves the right to modify the privacy outlined in the notice.

_____

Signature of Patient

_____

Patient's Date of Birth Today's Date

For Personal Representative of the Patient (if applicable):

_____

Print Name of Personal Representative

_____

Signature of Personal Representative

PLEASE NOTE THAT YOUR REFERRING PHYSICIAN WILL GIVE YOU THE RESULTS OF YOUR SCAN