ULTRASOUND Returning Patient

MRI Now

Patient Name	DOB	Have you received a new insurance card? Y N

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 oflast menstrual cycle
Y N History of kidney Problems	Weight:	Y N If female are you breastfeeding?

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

ASSIGNMENT OF INSURANCE BENEFITS

_____ *Initial*

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

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

YES____NO___

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 $30.00 service fee will be charged for all returned checks. I 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 Practices is available in the office******

Patient Signature Date