MRI Returning Patient

MRI Now

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

MEDICAL REVIEW

Y N Claustrophobic	Y N Artificial Heart Valve	Y N Stents or Shunts
Y N History of Cancer/ Multiple Myeloma	Y N Eye Implants	Y N Drug Infusion Devices
Y N History of Kidney Problems	Y N IUD/Pessary/Diaphragm	Y N If female, are you pregnant
Y N Are you on Dialysis	Y N Cardiac Pacemaker	Date of last menstrual cycle
Y N History of Diabetes	Y N Body Piercings	Y N If, Female are you breastfeeding?
Y N Prior Brain Surgery	Y N Pacing Wires	Y N Had metal removed from eye(s)
Y N Hearing Aids	Y N Dentures/ Partials	Y N Metal rods, pins, screws, etc.
Y N Nuerostimulators	Y N Any type of Prosthesis	Y N Bullets/Shrapnel
Y N Liver Disease		Y N Ear Jmplants
Y N Allergic Respiratory Disease		Y N Brain Aneurysm Clips

Are you taking any of the following medications? Glucophage Y N Glucovance Y N Metformin Y N	Allergies to: Iodine Y N CT Contrast Y N Gadolinium Y N MRI Contrast Y N
Previous MRI, CT, XRAY on same area Y N	Surgery on scanned area?
Where/When 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, MRI Now. I understand that any unpaid balance will be my responsibility.
Initial

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