

MRI NOW

Ultrasound New Patient

PATIENT NAME		GENDER M F	DOB	AGE	DATE
MAILING ADDRESS		MARITAL STATUS S M D W	SSN		HOME NUMBER
CITY, STATE, ZIP				WEIGHT	CELL NUMBER
CONTACT PERSON		RELATIONSHIP			PHONE NUMBER
REFERRING PHYSICIAN					

RESPONSIBLE PARTY (If different from above)

POLICY HOLDER (If different from above)

NAME		DOB	NAME		DOB
ADDRESS			ADDRESS		
PHONE		PHONE		SSN	
PRIMARY/SECONDARY INSURANCE			RELATIONSHIP TO PATIENT		

MEDICAL REVIEW

Y N Body Piercings (other than ears)	Y N IUD/Pessary/Diaphragm	<u>FEMALES</u>
Y N History of Cancer	Y N Metal Rods, Pins, Screws, etc.	
Y N History of Kidney Problems		
		Y N Are you pregnant?
		Date of last Menstrual Cycle:
		Y N Are you breastfeeding?

IMAGING HISTORY

Y N Previous MRI, CT, X-Ray on the same area?	Y N Surgery on scanned area
Where/When was it done?	

Are you here because of a work related auto, school or personal injury? Y N
Please explain:

****Your referring physician will be the one to give you the results of your exam.****

ATTENTION PATIENTS WITH MEDICARE INSURANCE

Y or N Have you made any changes to your Medicare coverage?

If so, please explain: _____

Y or N Are you currently in a skilled nursing facility?

Name of Facility: _____

Phone: _____

****IF YOU ARE IN A SKILLED NURSING FACILITY PLEASE NOTIFY THE FRONT DESK IMMEDIATELY****

Assignment of Benefits

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, I acknowledge that I have given **MRI Now** 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 that 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 my insurance is involved, **MRI Now** is contractually obligated to collect co-payments, co-insurance, and deductible as outlined by my insurance carrier. 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 \$25 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 Practice available in the office.**

Authorization for Use or Disclosure of Health Information

I hereby authorize the use and disclosure of individually identifiable health information relating to me, which is called "protected health information" under federal health privacy law, as described below:

I understand that I may revoke this authorization at any time by notifying **MRI NOW** in writing. However, if I choose to do so, I understand that my revocation will not affect any actions taken by **MRI NOW** prior to receiving my revocation.

HIPAA Authorization

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/or FILMS/CDs. 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. Your referring physician will give you your results.**

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 and Relationship: _____

Name and Relationship: _____

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

Signature of Patient

Signature of Personal Patient Representative (if applicable):

DOB

DATE

Print Name of Personal Representative