Ultrasound Returning Patient

Patient Name _____ Date of Birth _____ Y N New insurance card?

Medical Review

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

Imaging History

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

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

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. I acknowledge that I have given **MRI Now** the right to file to my insurance for payment of services rendered and to receive the payment from my insurance. 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.**

_____ _____

Patient Signature Date

MRI NOW

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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 authoization 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 physican 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