DEMOGRAPHICS

PATIENT INFORMATION

Date	Last Name	First Name	Middle Initial
Address		City	State	**Zip**
Sex	Date of Birth	Social Security #	Home Phone	Cell Phone
Email Address	Employed By	City	State	Work Phone

IF PATIENT IS A MINOR, PARENT INFORMATION

Relationship to Patient	Last Name	First Name	Social Security #
Home Address	City	State	Zip	Home Phone
Employed By	City	State	Work Phone
Spouse Name	Employed By	Phone

HEALTH INSURANCE INFORMATION

Primary Insurance Company	Policyholder	Date of Birth	Self	Spouse	Child	Other
Policyholder Social Security #	Member ID #	Group #	Insurance Phone #
Secondary Insurance Company	Policyholder	Date of Birth	Self	Spouse	Child	Other
Policyholder Social Security #	Member ID #	Group #	Insurance Phone #

AUTO ACCIDENT/WORKERS COMPENSATION

Accident? Circle One Yes No	Date of Accident/Injury	Place of Accident:	Work	Auto	Home	School	Other:
Your Auto Insurance Company	Claim Number	Adjuster Name	Adjuster Phone #
Law Firm	Attorney Name	Paralegal Name	Attorney Phone #

EMERGENCY CONTACT/SECONDARY CONTACT

Name of Nearest Relative or Friend	Address	Phone
How did you hear about US MRI?		

DIAGNOSTIC CONSENT

This procedure, together with any additional or different related procedures that in the opinion of the supervising physician or radiologist may be indicated, will be performed on you by the technologist. U.S. MRI maintains personnel and facilities to assist your physician and technologist in their performance of various diagnostic procedures. These procedures may all involve risks, unsuccessful results, complications, injury, or even death from both known and unknown causes. No warranty or guarantee is made as to results.

You have the right to be informed of the risks as well as the nature of the procedure, the expected benefits or effects of such procedure, and the available methods of diagnostics and their risks and benefits. Except in cases of emergency, procedures are not performed until you have had the opportunity to receive this information and have given your consent. You have the right to consent or to refuse any proposed procedure at any time prior to its performance. By signing this document, you certify that your physician and/or technologist have fully advised you of these matters. You authorize U.S. MRI to transfer you to another health care facility should the onsite physician determine it to be necessary. In addition, you also consent to the release of your medical records to such facility or other doctors, if needed.

Your signature below certifies that you have read and understood the information.

Provided in this form, the procedure set forth will be adequately explained to you by your technologist; you will have the chance to ask questions, be given all the information you desire concerning the procedure, and you authorize and consent to the performance of the procedures.

Signature _____Date _____ Relationship _____

SCREENING FORM

Date: _____

Name: _____

Current Weight: _____ lbs. Height: _____

What are your symptoms? _____

_____

_____

Was this the result of an injury? **YES** **NO**

If yes:

Date of injury: _____

Was this work related? **YES** **NO**

Was this due to a motor vehicle accident? **YES** **NO**

Please describe how you were injured: _____

_____

_____

Have you had surgery/injections on the affected area?

YES **NO**

List surgeries/injections and dates below:

Surgery/Injection	Date
_____	_____
_____	_____
_____	_____

List any movements or positions that increase symptoms: _____

_____

Have you had any previous x-rays, CT scans, or MRI scans for this problem? **YES** **NO**

When? _____

Where? _____

Have you felt a lump in the area we are scanning?

YES **NO**

Does your family have a history of cancer?

YES **NO**

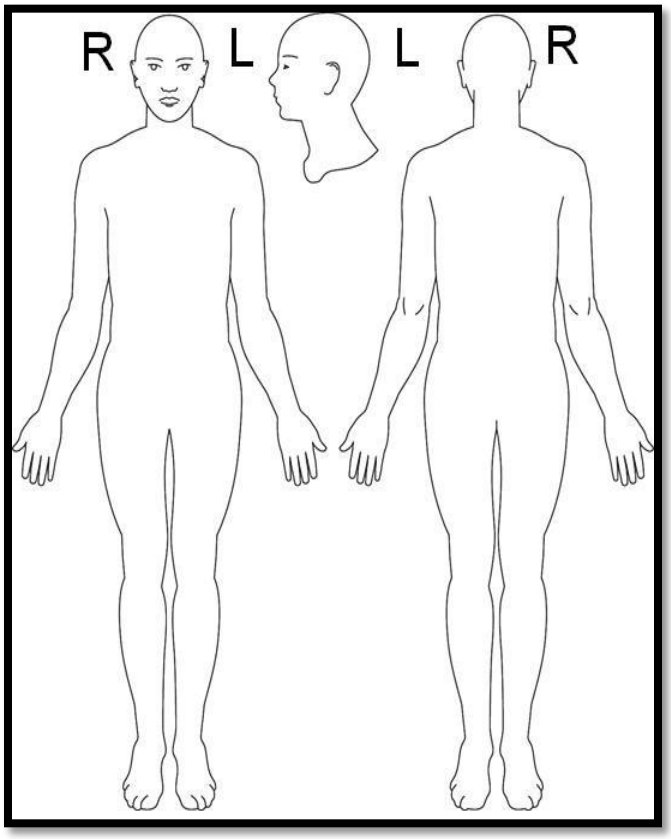
Are you diabetic?

YES **NO**

Symptoms Chart

(1) Circle where you have pain

(2) Shade where you have numbness/weakness



SCREENING FORM

BOX BELOW ONLY FOR THOSE HAVING CONTRAST

As part of your examination, your physician may deem it necessary to give you an injection of a contrast agent containing gadolinium (contrast or dye). This injection may help in more accurately diagnosing your condition. Although gadolinium contrast agents have been used safely in millions of cases, minor reactions (principally headache, nausea, or hives) occur in about 2% of patients.

HAVE YOU EVER HAD A REACTION TO GADOLINIUM CONTRAST MATERIAL? YES NO

I have been informed above of any risks and/or side effects with having gadolinium contrast. I understand fully and all my questions have been answered.

_____

Patient Signature

_____

Date

_____

Parent/Guardian Signature

_____

Date

Mark all that apply to you:

If any of these apply, please talk to radiology technologist.

- ☐ Neurostimulator
- ☐ Pacemaker
- ☐ Biostimulator
- ☐ Electronic implant device
- ☐ Spinal cord stimulator
- ☐ Insulin or infusion pum
- ☐ Defibulator
- ☐ Implanted cardioverter
- ☐ Implanted drug infusion device
- ☐ Pregnant
- ☐ Cardiac valve
- ☐ Stents
- ☐ Implants
- ☐ IUD
- ☐ Claustrophobic
- ☐ Renal insufficiency
- ☐ Epilepsy / history of seizures
- ☐ Prosthetic device
- ☐ Shrapnel / bullets / BB's
- ☐ Metal worker
- ☐ Dentures (Please remove prior to scan)
- ☐ Hearing aids (Please remove prior to scan)
- ☐ Artificial limbs or joints
- ☐ Aneurysm clips
- ☐ Tattoos
- ☐ Red blood cell disorder
- ☐ Rods, screws, plates, etc.
- ☐ **None**
- ☐ Any other surgically implanted device or objects: _____
  _____

Signature: _____

Date: _____ Relationship: _____

HIPAA AUTHORIZATION FORM

Authorization for Use or Disclosure of Protected Health Information
Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

1. Authorization

I authorize the following individuals to receive my protected health information:
Referring physician is included by default to receive medical records

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

☐ **Check this box if you do not wish to authorize anyone to have access to your health information.**

2. Effective Period

This authorization for release of information is for one year unless stated below:

☐ _____ to _____

☐ All past, present, and future periods

3. This medical information may be used by the person(s) I authorize to receive this information for medical treatment or consultation, billing, or claims payment, or other purposes as I may direct

4. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

5. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

6. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature _____ Date _____ Relationship _____

Printed Name _____

FINANCIAL POLICY

Patient Name _____

It is our office policy to inform you of our patient payment procedure. SLMRI/U.S. MRI bills insurance as a courtesy. The contract you have with your insurance is between you and your insurance carrier. That insurance contract is not between your carrier and SLMRI/U.S. MRI. If your services are provided through a lien, you are ultimately responsible if the attorney withdraws.

Please review the sections below.

1. You are responsible for deductibles, copays, noncovered services, coinsurance and items considered "not a covered benefit" by your insurance company. Please pay copayments and coinsurances amounts as services are rendered. Any balance unpaid after 90 days from the date of services were rendered will be considered "delinquent". If you or your insurance carrier make payments exceeding your balance reimbursement will be remitted. If payment cannot be made at each visit, notify the account coordinator so that other arrangements can be made. It is the responsibility of the patient to know their insurance plan. If you have given us erroneous information, you will be responsible for the balance.
2. Workers Compensation Patient
   As a worker's compensation patient, you may be covered by insurance if your injury is reported at work and verified with your employer. Be sure to inform the office personal that your injury resulted during employment. Patient is ultimately responsible for the balance. It is patient responsibility to give us correct information. We cannot place a lien on a worker's compensation case.
3. Personal Injury
   If you are a personal-injury patient, our office will bill the appropriate insurance company. Third-party companies cannot be billed. If we are unable to obtain payment, the charges for the services rendered will be your responsibility. Please give all information needed for billing at time of service. Patient is ultimately responsible for balance.
4. Return Check Charges
   A return check handling charge of 25.00 will be applied to all return checks.
5. Cash Pay
   Discounted cash pay prices are offered to patients with no insurance or high deductibles. We offer these discounts as a courtesy to help patients afford such services. If you are offered a cash price, you have waived the right to us of billing any insurance regarding this service. If no payments are made on the account after 90 days, the account will be sent to collections for the full price of the MRI plus collection fees.

Attorney's fees and cost: If any legal action is necessary to enforce the terms of this agreement, or if it is necessary to employ the services of an attorney, the patient agrees to pay the reasonable attorney fees and court cost in addition to any other relief to which we may be entitled. If the patient fails to pay any amount owing hereunder when due, or otherwise breeches any terms of this agreement, patient agrees to pay the collection expense incurred by SLMRI/U.S. MRI in attempting to collect such amounts from patient, in addition to the aforementioned attorney's fees and cost.

In the event any balance is not paid as agreed, the undersigned agrees to pay a collection fee not to exceed 40% of the unpaid balance. In the event of a lawsuit to collect the unpaid balance, the undersigned further agrees to pay court cost and reasonable attorney's fees in addition to the collection fee. You authorize us to call you at any number you provide or at any number at which we reasonable believe that we contact you, including calls to mobile, cellular, or similar devices for any lawful purpose. You agree to any fee or charges that you may incur for incoming calls from us, and /or outgoing calls to us, to or from any such number, without reimbursement from us.

Signature _____ **Date** _____ **Relationship** _____

Witness _____