

# DEMOGRAPHICS

## PATIENT INFORMATION

Date		Last Name			First Name			Middle Initial
Physical Address					City	State	Zip	
Mailing 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:

<u>Surgery/Injection</u>	<u>Date</u>
_____	_____
_____	_____
_____	_____

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**

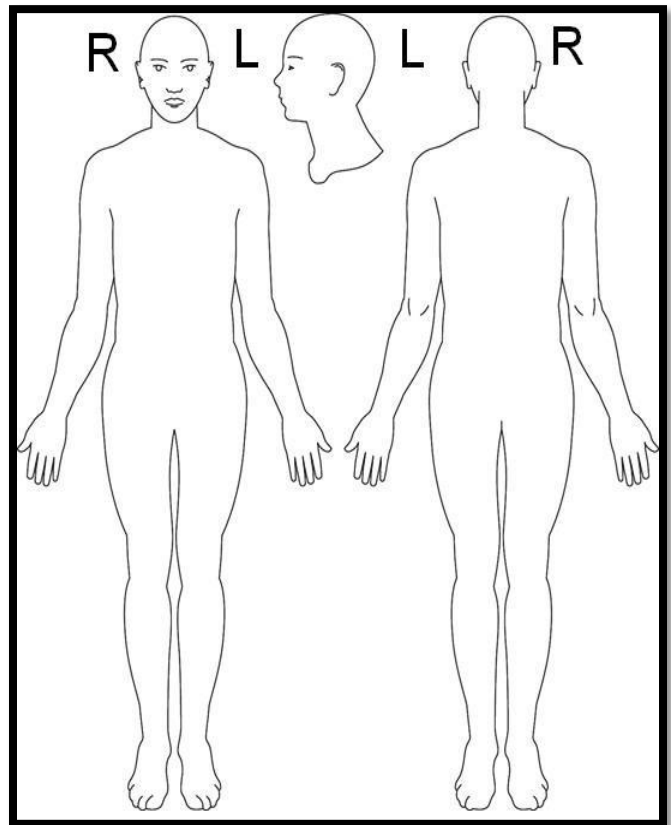
Are you diabetic?

**YES NO**

## Symptoms Chart

(1) Circle where you have pain

(2) Shade where you have numbness/weakness



# SCREENING FORM

## Mark all that apply to you:

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

### (CONTRAST PATIENTS ONLY)

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/Guardian Signature**

\_\_\_\_\_  
**Date**

Are you allergic to any medications?    **YES**    **NO**

If yes, please list: \_\_\_\_\_

\_\_\_\_\_

Please list all medications you are currently taking:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

- Neurostimulator
- Pacemaker
- Biostimulator
- Electronic implant device
- Spinal cord stimulator
- Insulin or infusion pump
- 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.
- Any other surgically implanted device or objects: \_\_\_\_\_
- \_\_\_\_\_
- None**

**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, if requested by me:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

\*Referring physician for today's visit will automatically receive the radiology results and does not need to be listed above.

**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 valid for one year from the date of service unless stated below:

\_\_\_\_\_ to \_\_\_\_\_

## 3. Related Visits

Please mark the box below in which you would like this authorization to apply to:

- Today's visit only
- All past, present, and future periods

4. 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
5. 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.
6. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
7. 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.
8. I understand that if I request my PHI to be emailed, that I accept the security risks that may exist for my PHI while it is in transit.

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 carefully review the sections below.

1. Health Insurance

**Please Note:** Deductibles, copays, and coinsurances cannot be determined until your health insurance has received and processed the claim. We cannot guarantee that our estimate is the exact amount that you will owe, but we do our best, based on our knowledge, to provide you with an estimate. Due to policy provisions in your contract with your insurance carrier, we are obligated to collect all patient responsibility balances. You are responsible for deductibles, copays, noncovered services, coinsurance and items considered “not a covered benefit” by your insurance company. Any balance unpaid after 90 days from the date of services were rendered will be considered “delinquent”. All delinquent accounts will be charged an interest rate of 1.5% per month (18% annum). 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 personnel 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 a high deductible. 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.

In the event any balance is not paid as agreed, the undersigned agrees to pay all collection costs. In the event of a lawsuit to collect the unpaid balance, the undersigned further agrees to pay court costs and reasonable attorney fees. You agree, for us to service your account or to collect any amounts you may owe, we may contact you by telephone at any phone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or e-mails, using any email address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

If you have additional questions or concerns upon reading these terms, please ask our office personnel.

**I have read this disclosure and agree to terms listed above.**

Signature \_\_\_\_\_ Date \_\_\_\_\_ Relationship \_\_\_\_\_

Witness \_\_\_\_\_