Patient Information

Name _____ ☐ Male ☐ Female

Date of Birth: _____ SS# _____

Mailing Address: _____

City _____ State _____ Zip _____

Phone Numbers: Home _____ Cell _____ Work _____

Emergency Contact: Name _____ Number _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Spouse Name: _____

Primary Insurance **(Section needs to be completed, if not fully completed patient will be billed for any services)**

Patients relationship to policy holder: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance Company _____ ID# _____ Group# _____

Policy Holder _____ DOB _____ SS# _____

Policy Holder Employer _____

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Unemployed ☐ Student

Secondary Insurance/Workman's Comp Information

Insurance Company _____ ID# _____ Group# _____

Policy Holder _____ DOB _____ SS# _____

Policy Holder Employer _____

Date of Injury Claim # Claims Address

Release of Medical Records

To complete my insurance claim and treatment, I authorize MRI of Arizona to release my medical records to my physician(s), clinic, hospital or insurance company (including government programs), and/or attorney, if being represented. Medical records are stored indefintely.

HIPAA – Notice of Privacy Practices

I acknowledge that a copy of the Notice of Privacy Practices that outlines how patient confidential information will be used, disclosed, protected, and how I can get access to this information, is available to me upon request.

Financial/Insurance Policy

I hereby assign all insurance benefits to MRI of Arizona for services performed, as a result of my illness or injury. **Non-insured patients.** I agree that I am responsible for payment at the time of service, unless prior arrangements have been made. **Deductible/Coinsurance.** I assume and agree to pay all applicable deductibles and co-pays. If my deductible is not met, full payment will be collected at time of service. If my deductible is met, my coinsurance amount will be collected at time of service. **Non-covered procedures.** I agree to pay for all non-covered services (preventative or routine) not paid by my insurance. **Collections.** Once an account is placed in collection status all future services must be paid in full at the time of service. I understand that there will also be a $25.00 returned check fee.

CD Policy

As a referred patient to MRI of Arizona, I understand that I am entitled to one disc per exam. Additional CDs will cost $10.00 per CD & require a 24 hour notice. Images are kept 6-7 years from last exam and longer if a minor, to meet State Guidelines.

Referral & Insurance Card Patient Responsibility

I understand that during the check in process, if I do not have my referral and/or insurance card I will be responsible for any payment rendered at the time of service. I also understand that I can avoid this expense by bringing my referral and/or insurance card to my scheduled check in time. I understand that I can call my referring Doctor's office and have these items faxed to MRI of Arizona's front office at 602- 294-9012 before the scheduled exam time.

Signature:

I have read and agree to abide by MRI of Arizona's policies.

_____ _____ _____

(Print Patient Name) (Patient/Responsible Party/Signature) (Date)

Last Name: _____ Acct # :

First Name: _____ **Age:** _____ **Weight:** _____

Physician Ordering MRI Exam: _____ Area to be Scanned: _____

Your medical information is confidential and protected by law. Accurate answers are necessary to ensure your safety and the correct interpretation of your exam.

YES	NO	
☐	☐	Do you have a **Pacemaker**. Implanted Defibrillator or Cardiac Wires
☐	☐	Aneurysm Clips in the Brain
☐	☐	Any Electronic, Magnetic or Mechanically activated implant or device in the body.
☐	☐	Have you ever had a metallic object in the eye? (Metal Slivers, Welding Fragment, etc…)
☐	☐	Any Vascular Clip, Filter, Stent or Shunt
☐	☐	Ear Implant, Stapes or **Cochlear Implant**
☐	☐	Eye Implant or Prosthesis
☐	☐	Joint Replacement, Screws, Pins, Clips
☐	☐	Hearing Aid, Removable Dental Work, TENS Unit
☐	☐	Body Piercings near area to be scanned. (Some exams require removal)
☐	☐	Is there any other metal that may be inside your body? _____
☐	☐	**Females**
☐	☐	
☐	☐	
☐	☐	Have you ever had a Cancer or Tumor in the body? _____
☐	☐	List any surgery you have had in the last six weeks: _____
☐	☐	Have you had a MRI exam before? _____ Location: _____

* If yes, was the MRI performed on the same body part we are scanning today? ☐ Yes ☐ No

Please list other imaging you have had *related to today's exam:* X-Ray C.T. Ultrasound Nuc Med

List Where and When: _____

Briefly describe your symptoms; reason for today's exam: _____

_____

Symptoms started _____ Is this the result of an injury or accident? _____ Date: _____

Have you had Surgery on the Region to be scanned? YES NO Date: _____

Describe: _____

Label the location of your symptoms, or Region of Interest on this figure:

Signature of Patient/ Guardian: _____

Date: _____ Technologist Initial: _____