Patient Information Form

Name: Date of Birth:

Address: Marital Status:

City: State: Zip: Student Status:

Home Ph: Cell: Gender:

SS#: Ethnicity (optional)

Contact Preference: Home phone Cell Phone Email Email Address:

Emergency Contact: Relationship: Phone:

Patient's Employer: Phone:

Address: City: State: Zip:

Allergies:

Primary Care Physician: Phone: Referred By:

Parent, Guardian or other Responsible Party Information

Name: Gender: Date of Birth:

Address: Marital Status:

City: State: Zip: Student Status:

Home Ph.: Cell Ph.: Work Ph.:

Employer: SS # Parent/Guardian:

Insurance

Primary Insurance: Secondary Insurance:

Insured: Phone: Insured: Phone:

Patient Relationship: Patient Relationship:

Insured ID #: Insured ID #:

Group #: Group #:

Previous Patient Yes No Paid Check Cash CC Amount Pd.

I Request Decline a copy of the Privacy Policy

Authorization

I hereby authorize release of information necessary for my insurance company to process my claim. The above information is correct to the best of my knowledge. I authorize payment directly to Midwest Imaging of Springfield (MRI of Springfield), insurance benefits otherwise payable to me. I understand that I am financially responsible for charges not paid in a timely manner by my insurance including Co-Pays, Co-Insurance, and Deductibles.

Signed: Date:

I AUTHORIZE THE FOLLOWING PERSONS TO HAVE ACCESS TO MY RECORDS PER HIPAA

Name	Relationship	Home or Cell Phone	Work Phone
Name	Relationship	Home or Cell Phone	Work Phone
Name	Relationship	Home or Cell Phone	Work Phone

Is it ok to leave messages for future appointments on the phone numbers listed? Yes ___ No ___
If not, is there a different number or person we should call? _____

ACKNOWLEDGEMENT OF COLLECTIONS and MEDICAL RECORDS POLICY

I understand I am responsible for all charges whether or not paid for by my insurance, including any and all collection fees, interest and/or legal fees incurred to collect unpaid balances. I understand legal actions including garnishments and/or property liens may be used for collections.

Midwest Imaging of Springfield will provide one original set of images for the patient in the event they are needed for follow up appointments. It is the patient's responsibility to inform Midwest Imaging of Springfield, of any appointment dates/times in which the images would be needed for other doctors and or facilities.
I understand it is my responsibility to maintain the copy of my images for future appointments if I take them with me today. I further understand that if I want/need additional copies of reports and/or images generated through this office there will be a $10.00 medical records charge. **Midwest Imaging of Springfield kindly requests 24 hour advance notice in order to have images/medical records available for pickup.**

Printed Name **Signature of Patient of Patient Representative**

By patient on day of service ____YES ____NO Verified by Staff _____ Date _____

FLAT RATE PRICING AGREEMENT

I, _____ do not have insurance, or I do not wish to have Midwest Imaging of Springfield., file insurance for me. I understand I have been given a considerable discount and in order to receive this discount I must pay the discount price of $ _____ in full at the time of my appointment.

I further understand that if I have Insurance, I waive my right to have Midwest Imaging of Springfield., bill my insurance for services I receive today.

_____
Printed Name of Patient Signature of Patient or Guardian

Signature of staff member Date Verified by

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