Patient Information Form

Name: Date of Birth:

Address: Marital Status:

City: State: Zip: Student Status:

Home Ph: Cell: Gender:

SS#:

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 or Guardian 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 the claim. The above information is correct to the best of my knowledge. **I authorize payments directly to Midwest Imaging / 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, deductibles or any unauthorized re-pricing by your insurer.** ***For self-pay patients see next page.***

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 your 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/MRI 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 $15.00 medical records charge. You have a right to your **Images/medical records.** You may pick them up at any time between 8am & 5pm Monday through Friday. Please call in advance if you are picking up records for a referral. You will have a wait time for your images to be burned onto a CD. You must show a Photo ID to obtain records.

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

FOR FLAT RATE PRICING AGREEMENT OR SELF-PAY PATIENTS PLEASE COMPLETE

By patient on day of service ____ YES ____ NO Verified by Staff _____ Date _____

I, _____ **do not have insurance**, or **I do not wish to have Midwest Imaging / MRI of Springfield, file insurance for me.** I understand that I have been given a **considerable discount** and in order to receive this discount **I must pay for 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 / MRI of Springfield bill my insurance for services that I receive today. I further understand with the self pay rate, I waive my right to or for any type of insurance refund or adjustment if I submit a request or ledger to my insurance company or third party's administrator to apply towards my deductible, I will not receive a refund from Midwest Imaging / MRI of Springfield.

Printed Name of Patient Signature of Patient or Guardian

Signature of staff member Date