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.

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.

Film Policy

As a referred patient to MRI of Arizona, I understand that I am entitled to one set of films/disc per exam, upon request. Each additional set of films will cost $30.00 per procedure. I understand that MRI of Arizona requires a 24 hour notice to print films.

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: _____ Male **D.O.B:** _____

First Name: _____ Female **Height** _____ **Weight** _____

Check if any of the following apply to you. They may be harmful to you or interfere with your MRI results.

Yes	No		Yes	No	
☐	☐	Cardiac Pacemaker	☐	☐	Surgical fixation devices:(Circle) Screws, Pins, Rods, Plate,Wire
☐	☐	Implanted Cardiac Defibrillator	☐	☐	Spinal fixation device, Fusion, Halo Vest or Spinal Cord Stimulator
☐	☐	Internal electrodes or wires	☐	☐	Surgical clips, staples, mesh or Breast Tissue Expander
☐	☐	Aneurysm Clip	☐	☐	Implant activated by/or held in place by magnet
☐	☐	Neurostimulator	☐	☐	Radiation Seeds (Cancer Treatment)
☐	☐	Any Stimulus Device Implant	☐	☐	Coil or Filter in Vessels
☐	☐	Implanted Drug Pump	☐	☐	Stent Make,Model,Implant Date: _____
☐	☐	Cochlear Implant	☐	☐	Shunt Type _____
☐	☐	Middle Ear Implant	☐	☐	IV access port (Broviac, PortACath,Hickman,SwanGanz,Thermodilution Cath)
☐	☐	Artificial Eye, Eyelid Spring	☐	☐	Pregnant or Nursing Mother
☐	☐	Artificial Joint or Limb	☐	☐	IUD, Pessary or Diaphragm
☐	☐	Artificial heart valve	☐	☐	Penile Implant

☐ ☐ Any injury to the eye from a metallic object? (Metallic Slivers, Shavings,Welding Fragment, etc…)

☐ ☐ Injury from metallic object (Schrapnel, Bullet) that required medical attention:

☐ ☐ Any metal in body not mentioned above: _____

☐ ☐ Have you ever had an MRI exam before? Any problems/complications/reactions? _____

☐ ☐ TENS Unit ☐ ☐ Medication Patch ☐ ☐ Permanent make-up

☐ ☐ Hearing Aid ☐ ☐ Body Piercings or Tattoo ☐ ☐ Eye make-up (Remove for Brain/Orbit scans)

☐ ☐ Dentures, Removable dental work, Oral braces or retainer ☐ ☐ Wig or Hair Implants

☐ ☐ Diagnosed with Cancer? Location in Body: _____

Treatment : ☐ Surgery ☐ Radiation ☐ Chemotherapy Other: _____

List previous imaging related to today's exam: ☐ MRI ☐ C T ☐ Other _____

Location & Date: _____

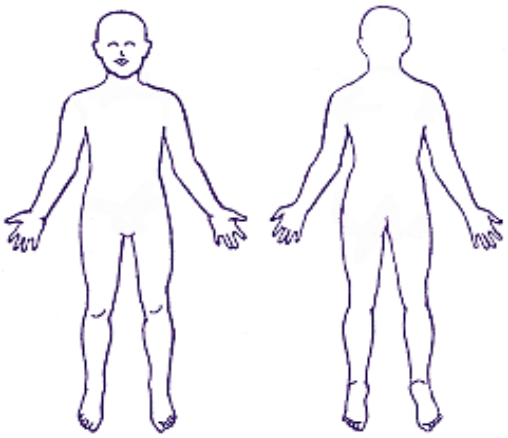
Reason for MRI and/or Symptoms: _____

When did symptoms start? _____ ☐ Injury ☐ Work-Injury ☐ Motor Vehicle Accident ☐ No Known Injury

Have you had surgery on Region to be scanned? ☐ Yes ☐ No Date of Surgery: _____

Describe surgery performed: _____

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



Patient /Parent /Guardian /Other Signature

Date

Technologist Date