Patient Information Form

Name:			Date of Birth:
Address:			Marital Status:
City:	State:	Zip:	Student Status:
Home Ph#:		Gender:	Cell Phone:
SS#:		Email:	
Contact Preference: Home Cell E-Mail			Phone:
Employer:			
Address:			Work Ph#:
City:	State:		Zip:
Allergies:		PCP:	
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# of Parent or Guardian:		

Insurance

Primary Insurance:	Secondary Insurance:
Insured:	Insured:
Patient Relationship:	Patient Relationship:
Insured ID #:	Insured ID #:
Group #:	Group #:
Co Pay :	Co Pay :

Previous Patient: Yes No

Paid: Cash Check CC Amount:

I Request Decline a copy of this Policy

Emergency Contact Information

Relationship:	Name:	Ph#:
Relationship:	Name:	Ph#:

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 Center LLC, insurance benefits otherwise payable to me. I understand that I am financially responsible for charges and paid in a timely manner by my insurance including Co-Pays, Co Insurance, and Deductibles. 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

I ____ Authorize _____Do Not Authorize Midwest Imaging Center LLC to leave messages on my home/cell phone regarding appointments, payments, and/or billing.

ACKNOWLEDGMENT OF MEDICAL RECORDS POLICY

Midwest Imaging Center LLC 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 Center LLC 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 Center LLC kindly requests 24 hour advance notice in order to have images/medical records available for pickup. You must show a photo ID to obtain these records.

I _____ Request _____ Decline a copy of the Privacy Policy.

PRINTED NAME SIGNATURE OF PATIENT OR PATIENT REPRESENTATIVE

FLAT RATE PRICING AGREEMENT/SELF PAY

I, ___________________________ do not have insurance, or I do not wish to have Midwest Imaging Center LLC, file insurance for me. I understand I have been given a considerable discount and to receive this discount I must pay the discount price of $_______ in full at the time of my appointment for date of service of ___________.

I further understand that if I have Insurance, I waive my right to have Midwest Imaging Center LLC bill my insurance for services I receive today. I further understand that with self-pay rate, I waive my right to/for any type of insurance refund or adjustment, if I submit a ledger to my insurance company or third party's administrator; I will not receive a refund from Midwest Imaging Center LLC.

PRINTED NAME **SIGNATURE OF PATIENT OR**
PATIENT REPRESENTATIVE