CENTRAL IMAGING "OPEN" MRI

BONE DENSITY

TODAY'S DATE __________

PATIENT NAME: ____

ADDRESS:____ APT#:________

CITY:______________________STATE________________ZIP:__________

HOME TELEPHONE #:__________________CELL PHONE#:____________________

DATE OF BIRTH:__________________SOCIAL SECURITY#:______________SEX: M OR F

PRIMARY INSURANCE:________________ ID/GROUP#:____________________

ADDRESS:____

SECONDARY
INSURANCE:____________________ID/GROUP#:____________________

ADDRESS:____

REFERRING DOCTOR: ________________________TELEPHONE #: ____________

Gynecologic History (WOMEN ONLY)

- Have you had a hysterectomy? If yes, what age? __________
- Were your ovaries removed? If yes, Right___ Left___ or Both___
- Have you entered Menopause? If yes, what age? __________
- Are you taking hormone replacement pills or using a hormone patch? If yes, which one? __________

Medical Information

- What is your estimated height? __________ weight?__________
- Do you have osteoporosis? If yes, what medication do you take for it? ____________________
- Do you take cortisone, prednisone or any other steroid? If yes, which one? ____________________
- Do you take daily vitamin D or Calcium supplements? If yes, which one? ____________________
- Do you take a multivitamin? Yes or No
- Do you have any thyroid medical condition? If yes, hyper or hypo? ____________________
- Do you currently smoke cigarettes? Yes or No
- As an ADULT, have you had any fractured bones? ____ If yes, which ones? ____________________
- Do you drink alcohol? _____ If yes, do you drink 3 or more alcoholic drinks a day?______________
- Ethnicity: Asian__ African American__ Hispanic__ Caucasian__ Other__

Office use ONLY

77080 – Lumbar / Hips   77081 – Forearm   77086 – LVA

CONSENT, AUTHORIZATION FOR RELEASE OF INFORMATION

MEDICAL CONSENT: I consent to the examination, treatment, and procedures, which may be performed during the visit, including emergency treatment, considered necessary by my physician.

RELEASE INFORMATION: I authorize the above named provider to release any information needed to process the claims in reference to the examination, treatment, or procedures rendered by the provider. I further permit a copy of this authorization to be used in place of the original. I authorize the above named provider to request any information/records from other medical providers needed to help the process of my medical claim with Central Imaging Open MRI, Inc.

FINANCIAL RESPONSIBILITY: I understand that payment is due in full at the time of service and if not, I acknowledge that I am responsible to make the appropriate financial agreements including but not limited to insurance benefits, should my account become delinquent or be referred to any third party for collection efforts I agree to pay all reasonable interest, attorney fees, court costs and/or collection expenses. I agree in order for Central Imaging Open MRI, Inc. to collect any amounts I may owe, they may contact me by telephone at any number associated with my account, including wireless telephone numbers, which could result in charges to me.

MEDICARE/MEDICAID BENEFITS ONLY: If applicable, I certify that the information given by me in applying for payment under Title XVIII and/or XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed to this or a related Medicare/Medicaid claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to Central Imaging Open MRI/Bay Diagnostics. I authorize the above named provider to submit to Medicare and/or Medicaid for payment on my behalf.

Patient signature: ______________________________ Date: ______________

Please tell us with whom we may discuss your protected health information:

Name:______________________________ Relationship:______________

Name:______________________________ Relationship:______________

I, __________________________,have been Informed of the Notice of Patient Privacy Practices made available by Central imaging Open MRI, Inc.

Patient signature: ______________________________Date: ______________

ASSIGNMENT, LIEN AND AUTHORIZATION

INSURANCE BENEFITS

To Whom It May Concern:

I, ____ hereby authorize and direct you, my insurance company and/or my attorney, to pay directly to **Central Imaging Open MRI, Inc**. ("Assignee") such sums as may be due and owing Assignee for services rendered me, both by reason of accident or illness and by reason of any other bills that are due Assignee, and to withhold such sums from any disability benefits, medical payment benefits, No-Fault benefits, or any other insurance benefits obligated to reimburse me or from any settlement, judgment or verdict on my behalf as may be necessary to adequately protect said Assignee. I hereby further give a lien to said Assignees against any and all insurance benefits named herein and any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by Assignee. This is to act as an assignment of my rights and benefits to the extent of the Assignee's services provided. This assignment of benefits includes, but is not limited to, assignment of my right to file suit for non-payment and/or underpayment of insurance benefits. **Further, I hereby instruct the insurance carrier to request that, in the event the subject medical services and/or benefits are disputed for any reason, the amount of benefits being claimed by Central Imaging Open MRI, Inc. are to be held in escrow and not disbursed until the dispute is resolved.**

In the event my insurance company obligated to make payments to me upon the charges made by Assignee for their services refused to make such payments, upon demand by me or Assignee, I hereby assign and transfer to Assignee any and all causes of action that I might have or that might exist in my favor against such company and authorize Assignee to prosecute said cause of action either in my name or in Assignee name and further I authorize Assignee to compromise, settle or otherwise resolve said claim or cause of action as they see fit.

I authorize Assignee to release any information pertinent to my case to any insurance company, adjuster or attorney to facilitate collection under this Assignment, Lien and Authorization. I agree that the above mentioned Assignee be given Special Power of Attorney to endorse/sign my name on any and all checks and claim forms for payment of my bill.

Dated this______________ day of ______________________, 20____.

______________________ ______________________

Claimant **Witness**