

## VESTAVIA MRI, LLC

<b>ACCT #:</b>	<b>Appointment Date &amp; Time:</b>			<b>DOB:</b>
<b>Name:</b>	<b>Last:</b>	<b>First:</b>	<b>MI:</b>	<b>SSN:</b>
Address:		City:	State:	Zip:
Home Phone:		Cell Phone:		Sex: M F
Employer:		Work Phone:	Married/Single	
Spouse's Name:		Emergency Number:		

**PRIMARY INSURANCE:** \_\_\_\_\_ Is it in your name? YES NO

If NO, Policy Holder's Name: \_\_\_\_\_ Relation: \_\_\_\_\_ DOB: \_\_\_\_\_

**SECONDARY INSURANCE:** \_\_\_\_\_ Is it in your name? YES NO

If NO, Policy Holder's Name: \_\_\_\_\_ Relation: \_\_\_\_\_ DOB: \_\_\_\_\_

I certify that the above information is true and correct: \_\_\_\_\_

**Patient Signature**

<b>OFFICE USE ONLY</b>
------------------------

EXAM ORDERED: \_\_\_\_\_

DIAGNOSIS: \_\_\_\_\_ Date Ordered: \_\_\_\_\_

REFERRING MD: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

UPIN # \_\_\_\_\_ NPI# \_\_\_\_\_

Insurance Precert checked by: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Coverage: \_\_\_\_\_ Deductible: Yes No \$ \_\_\_\_\_ met \$ \_\_\_\_\_

Payment Amount: \_\_\_\_\_ by: Cash Check Visa MC Amex

# Vestavia MRI, LLC

**Assignment of benefits:** The undersigned assigns to and authorized the benefits payable for radiological services to Vestavia MRI, Inc.

**Authorization to assign Benefits and release Information to Medicare/Medicaid:** I certify the information given to me in applying for payment under Title XVIII 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 and Centers for Medicare and Medicaid Services or its intermediaries any information needed for this or other related Medicare claims. I request the payment of authorized benefits be made on my behalf to Vestavia MRI, Inc.

**Financial Responsibility:** The undersigned is agreeable and understands that Vestavia MRI, Inc. charges that are not paid may be placed with a collection agency and that I will be responsible for the payment of the amount due including any collection fees, and attorney fees.

I understand that my insurance company may consider this procedure(s) to be a non-covered service(s) and may not pay for this procedure. Therefore, I agree to assume the financial responsibility for this medical care and to pay the full charge of the services.

**Patient Consent Agreement:**

I understand that as part of my healthcare, Vestavia MRI, Inc. originates and maintains health records describing my health history, symptoms, examination, test results, diagnosis, treatment, and plans for future care or treatment. I understand this information serves as a basis for my treatment and diagnosis, a means of communication among other health professionals who contribute to my care, and a source of information for payment requirements for medical insurance companies. I authorize Vestavia MRI, Inc. to release medical or other personal information orally, written or electronically which may be necessary for the completion of insurance forms, payment for services, review of services, further treatment or receipt of benefits.

I have been provided with a copy of Vestavia MRI's Notice of Privacy Practices concerning how the use and disclosure of my Protected Health Information will be handled by this practice.

Signature \_\_\_\_\_ Date \_\_\_\_\_  
(Patient or Responsible Party)