



For proper insurance billing. If left blank, billing will be returned for completion.

PATIENT INFORMATION

Name: _____
Last name First Name M.I.

Soc. Sec. # _____

Street Address: _____

City: _____ State: _____ Zip _____

Phone: _____

Other Number(s): _____

Sex: Male Female Age: _____ Date of Birth: _____ Marital Status: Single Married Divorced

Spouse's Name: _____

Emergency Contact: _____ Relation: _____ Phone: _____

How did you hear about us?

PRIMARY INSURANCE

Subscriber's/Guarantor's Name: _____
Last Name First Name M.I.

Relation: _____ **SUBSCRIBER DATE OF BIRTH:** _____ **SUBSCRIBER SOC.SEC.#:** _____

Subscriber's Address: _____ Phone: _____
(if different from patient's)

Employer: _____

Insurance Company: _____

Insurance Company's Address: _____ Phone: _____

Group#: _____ Policy#: _____

ADDITIONAL INSURANCE

Is this patient covered by additional insurance? No Yes

Subscriber's/Guarantor's Name: _____
Last Name First Name M.I.

Relation: _____ **SUBSCRIBER DATE OF BIRTH:** _____ **SUBSCRIBER SOC.SEC.#:** _____

Subscriber's Address: _____ Phone: _____
(if different from patient's)

Employer: _____

Insurance
Company: _____

Insurance Company's
Address: _____ Phone: _____

Group#: _____ Policy#: _____

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Northwestern Medical Imaging

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ Medical Record No. _____

Address: _____

I have been given a copy of Northwestern Medical Imaging's ("NMI") *Notice of Privacy Practices* ("Notice"), which describes how my health information is used and shared. I understand that NMI has the right to change this *Notice* at any time. I may obtain a current copy by contacting the Facility.

My signature below acknowledges that I have been provided with a copy of the *Notice of Privacy Practices*:

Signature of Patient or Personal Representative

Date

Print Name

Personal Representative's Title (e.g., Guardian, Executor of Estate, Health Care Power of Attorney)

For Facility Use Only: Complete this section if you are unable to obtain a signature.

1. If the patient or personal representative is unable or unwilling to sign this *Acknowledgement*, or the *Acknowledgement* is not signed for any other reason, state the reason:

2. Describe the steps taken to obtain the patient's (or personal representative's) signature on the *Acknowledgement*:

Completed by:

Signature of Facility Representative

Date

Print Name

File original in patient's Business Office Record



AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS AND FILMS

Patient Name: _____
Social Security Number: _____
Date of Birth: _____

To: Doctor/Person/Institution: _____
Doctor/Institution Address: _____
City: _____ State: _____
Zip: _____
Primary Doctor: _____

To: Northwestern Medical Imaging

I, the undersigned, hereby authorize Northwestern Medical Imaging to furnish to the above named medical care provider at the above address, to entities involved in billing and collection, and third party payors responsible for payment of patient charges any and all information which may be requested regarding my past or present physical condition, treatment rendered, and diagnostic tests performed and to allow them or any physician appointed by them to examine and copy any and all bills, reports, records, and any films, or computer record of any test taken of me. I also understand that this Authorization is subject to revocation/withdrawal by me at any time in writing to the medical record contact person at this site except to the extent that action has already been taken to release this information. This Authorization shall remain valid unless revoked but will expire in one year after signing. I have a right to inspect a copy of the health information to be released and if I do not sign this authorization, Northwestern Medical Imaging will not refuse to treat me based on whether I agree to allow my health information to be used and disclosed to others.

ASSIGNMENT OF BENEFITS

In consideration of services rendered at Northwestern Medical Imaging, I hereby assign and authorize direct payment to Northwestern Medical Imaging of any insurance, health plan, third party benefits, Medicare, or Medicaid benefits otherwise payable to me or on my behalf for these services.

Any copy of this authorization shall be considered as valid as the original.

Signature of Patient or Legal Guardian/Rep.

Date



OFFICE AND PAYMENT POLICIES

Welcome to Northwestern Medical Imaging, LLC (**NMI**). Our professional staff is committed to your health and welfare. Following is a statement of our office and payment policies.

1. Authorization.

a. **Treatment.** I, the undersigned Responsible Party, desire to receive medical services for myself or my dependants. By signing below I authorize NMI to provide medical services to me, my spouse, my children or legal dependants.

b. **Release of Medical Information.** I authorize NMI, in its sole discretion, to release any and all medical information about my spouse, my dependants, or myself to my insurance carriers, and I agree to assign my rights in the health insurance benefits for my spouse, my dependants or myself to NMI.

2. Financial Responsibility. I understand that while I may have health insurance coverage, I am financially responsible for the payment of all charges for service rendered to me or my dependants at NMI. I will pay for any and all services provided to my spouse, my dependants or myself that have not been paid for by my health insurance provider, regardless of whether the charge is deemed medically necessary by my insurance company.

3. Missed Appointments. I understand that if my spouse, my dependants or I cancel an appointment with less than 24 hours advance notice, your office reserves the right to charge a missed cancellation fee of \$30.

4. Minor and Adult Children of Responsible Party.

a. **Court Ordered Support.** I agree that I will be responsible for services provided to my dependants regardless of the relationship to the adult accompanying that dependant and regardless of the rights or obligations established between the adult accompanying a minor patient and another adult, as may be provided in a divorce decree or other court order.

b. **Minors not accompanied by a Responsible Party.** I agree that NMI reserves the right to deny non-emergency treatment for minors not accompanied by a Responsible Party, unless charges have been pre-authorized to an approved credit plan, credit card, and payment in cash or by a check at the time of service.

c. **Minor Children reaching the age of Majority (Adult Children).** If an Adult Child continues to seek treatment after reaching the age of majority I will continue to be financially responsible for the Adult Children until the Adult Child enters into a separate arrangement accepting financial responsibility for the services rendered.

5. Returned Checks. I understand that if the bank returns my check for services rendered by NMI, then NMI will impose a \$30.00 processing fee. This fee will be added to my account, and I will be responsible for the payment of this fee. In addition, I understand that this office reserves the right to refer all bad checks to the District Attorneys' Office for prosecution.

6. Delinquent Accounts.

a. **Late Charges.** I understand that NMI will add a late fee to my account if I fail to pay my account within thirty (30) days from the date of my statement or fifteen (15) days after I receive any check from my insurance carrier in reimbursement for services rendered to me as a patient of NMI, whichever occurs later. The late fee charge is currently \$50.00. I understand that I am solely responsible for this late fee and that it will not be billed to my insurance company.

b. **Interest and Delinquent Accounts.** I understand an account is a Delinquent Account if it remains unpaid upon the later of either of the following dates: 30 days after NMI sends a statement or invoice for services; or fifteen (15) days after I receive a check from my insurance carrier in reimbursement for services rendered to you, or your dependants as a patient of NMI. The remaining balance is subject to a finance charge of 1.5% per month (18% per year).

c. **Attorney Fees.** If an account is unpaid for 90 days or more, NMI may refer the account to its attorneys for collection. I understand and agree that I will pay all costs and expenses associated with the efforts to collect on the Delinquent Accounts, including reasonable attorneys' fees, costs and interest charges assessed in accordance with law.

Acknowledgement and Release. By signing below, Responsible Party agrees to the terms of the Office Policy and Payment Policies outlined above.

Signature of Responsible Party

Date

Printed Name

Patient's Printed Name



GENERAL HISTORY INFORMATION

Account # _____ -

Patient Name: _____ Date of Birth: _____ Age _____ Date: _____

Patient's **Weight** _____ **Height** _____ **Ordering Doctor's Name** _____

1. Why did the Doctor order this exam? (Why did you go see the Doctor?)
 Injury Pain Swelling Other reason _____
Please also **list area of pain or swelling** and other symptoms: Please be specific

2. Known medical problems relating to area being scanned: _____

3. Any prior tests **of area being scanned** today? (Check any that applies) MRI, X-ray, CT, Ultrasound When? _____
At which facility? _____

4. List any surgery, biopsy, injections, or treatment related to the area being scanned

5. Personal History of cancer? Yes No
If yes, then list primary source _____

6. Any radiation or chemotherapy? Yes No If yes, when? _____

7. Is this a follow-up or check-up exam? Yes No
If **yes**, do you have any **new** symptoms?

8. Are your symptoms due to Injury or Trauma? Yes No If yes, when? _____
What type of Trauma? _____

TECHNOLOGIST NOTES