

PATIENT INFORMATION

Address	Last Name	Fin	st	Middle Int	: M/F
Celi#	Address			Apt. #	
Date of Birth	City	State/Zip	H	lome#	
Primary Insurance	Cell#	Email			
Name of Insured (if other than patient) Insured's info Date of Birth: Social Sec # ACCIDENT: Is this injury a result from an accident: Yes / No Auto Work Date of accident: / Claim number: Auto Insurance: Adjuster: Autorney Name Phone: How did you hear about Beaches? (Circle) Doctor Friend Online Insurance By signature below, I understand that Beaches MRI (hereinafter BMRI) has agreed to provide me (patient or patient's guardian) with the important health care imaging service ordered by my doctor, even if my insurance company has denied, delayed or failed to authorize the service. I further recognize that BMRI will do everything possible with my doctor to convey the importance and necessity of the imaging service to my insurance company, but I understand and agree that I am ultimately financially responsible for any cost my insurance company denies or does not pay for any reason. In addition, I authorize payment of medical benefits directly to BMRI. This assignment includes but is not limited to all rights to collect benefits directly from my insurance company or HMO for those services I have received and all rights to proceed against my insurance company or HMO for those services I have received and all rights to proceed against my insurance company or HMO fails to make payments of benefits that are due to BMRI. This assignment also includes the right to recover any attorney fees and costs for such action brought by BMRI as my assignee. If I have requested that my insurance company hold my benefits for lost wages, I hereby release those amounts necessary to pay for services provided by MBRI. Furthermore, I direct my attorney to withhold funds and pay BMRI directly for the imaging services they have provided, from any recovery I may have. I understand that BMRI will be paid by me. I authorize BMRI to release any and all information requested by any insurance company	Date of Birth/	/ Socia	l Sec. #	<u> </u>	
Insured's info Date of Birth:		:========	:=======	:========	========
ACCIDENT: Is this injury a result from an accident: Yes / No Auto Work Date of accident: / Claim number: Auto Insurance: Adjuster: Attorney Name Phone: How did you hear about Beaches? (Circle) Doctor Friend Online Insurance By signature below, I understand that Beaches MRI (hereinafter BMRI) has agreed to provide me (patient or patient's guardian) with the important health care imaging service ordered by my doctor, even if my insurance company has denied, delayed or failed to authorize the service. I further recognize that BMRI will do everything possible with my doctor to convey the importance and necessity of the imaging service to my insurance company, but I understand and agree that I am ultimately financially responsible for any cost my insurance company denies or does not pay for any reason. In addition, I authorize payment of medical benefits directly to BMRI. This assignment includes but is not limited to all rights to collect benefits directly from my insurance company or HMO for those services I have received and all rights to proceed against my insurance company or HMO for any action including legal suit if for any reason my insurance company or HMO fails to make payments of benefits that are due to BMRI. This assignment also includes the right to recover any attorney fees and costs for such action brought by BMRI as my assignee. If I have requested that my insurance company hold my benefits for lost wages, I hereby release those amounts necessary to pay for services provided by BMRI. Furthermore, I direct my attorney to withhold funds and pay BMRI directly for the imaging services they have provided, from any recovery I may have. I understand that BMRI wifile my insurance claim as a courtesy to me, and that any amounts not covered by any insurance company by me. I authorize BMRI to release any and all information requested by any insurance company	Primary Insurance		Secondary	/	
Accident: Is this injury a result from an accident: Yes / No Auto Work Date of accident: / / Claim number: Auto Insurance: Adjuster:	Name of Insured (if other	than patient)			
Accident:	Insured's info Date of B	irth:	Social Sec #		
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	By signature below, I under me (patient or patient's guadoctor, even if my insurance recognize that BMRI will do necessity of the imaging sultimately financially responses. In addition, I authoricludes but is not limited for those services I have reany action including legals of benefits that are due to and costs for such action I company hold my benefits services provided by BMRI for the imaging services the file my insurance claim as paid by me. I authorize BMRI	rstand that Beaches Mardian) with the imported company has denied everything possible ervice to my insurance onsible for any cost my orize payment of medito all rights to collect eceived and all rights to suit if for any reason reason or borought by BMRI as more for lost wages, I here a courtesy to me, and IRI to release any and	MRI (hereinafter BM tant health care imaged, delayed or failed with my doctor to de company, but I ure y insurance compand benefits directly from the proceed against my insurance compant also includes the passignee. If I have by release those and the my attorney to with any recovery I many recovery I many that any amounts in that any amounts in that any amounts in the care in	RI) has agreed to paging service order to authorize the sconvey the importanderstand and agreed to BMRI. This assumed in the requested that mounts necessary to the fold funds and pay have. I understand to covered by my	provide red by my ervice. I further nce and the that I am not pay for any signment ompany or HMO pany or HMO in to make payments ny attorney fees ny insurance to pay for pay BMRI directly and that BMRI wil insurance will be