Welcome Back to Beaches MRI

Patient Name: _____ DOB: _____ Last 4 SS #: _____

Has your phone number changed? Yes / No (New Number) _____
Has your address changed? Yes / No (New Address) _____
Has your insurance changed? Yes / No (New Insurance)Primary:_____ Secondary:_____

Is the problem you're experiencing due to an auto accident? Yes / No Date of Accident : _____
Auto Insurance/Adjuster: _____ Claim #: _____
Attorney Name/ Phone # _____

Give a Detailed description of your symptoms to the area being scanned (Reason for Dr. visit).

_____
List All surgeries and Any medical conditions (DO NOT LEAVE BLANK!)

List your Allergies: _____
List your Medications: _____

-Do you have any metal or metal device inside your body? (Aneurysm Clip, Vascular Stent, foreign body, etc.) Yes___ No_____
-Do you have any electronic device inside your body? (Pacemaker Spinal Stimulator, Any Implant, Pump, etc.) Yes___ No_____
-Do you have renal (kidney) failure?
-Any possibility that you are pregnant or breastfeeding? Yes___ No_____
-Have you ever had cancer? If "yes", what type_____ Yes___ No_____
-Have you ever had an MRI before? If "yes", what type and where_____ Yes___ No_____

Your Weight _____ Your Height _____ Do you smoke? No / Yes, How much? _____

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. I also agree and consent to service performed including contrast administration. 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 in 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 will file my insurance claim as a courtesy to me, and that any amounts not covered by my insurance will be paid by me. I authorize BMRI to release any and all information requested by any insurance company billed, in order to complete my insurance claim.

Signature:_____ Print your name:_____ Date:_____

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TECH'S COMMENTS:_____

_____

Exam Completed Date/Time:_____/_____am/pm Gad-Opti Mark:_____cc's IV Site:_____

Read By: _____ ID# _____ Archived _____ Spelling _____ Tech: _____

Prior Exam Type/Date-Beaches_____ Outside_____