NMI NORTHWESTERN MEDICAL IMAGING

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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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

MRI CHECKLIST

☐ Yes OR ☐ No **CARDIAC PACEMAKER?** ****** PATIENT CANNOT HAVE MRI ******

☐ Yes OR ☐ No **IMPLANTED CARDIAC DEFIBRILLATOR?** ****** PATIENT CANNOT HAVE MRI ******

☐ Yes OR ☐ No ANEURYSM CLIP(S)?

☐ Yes OR ☐ No BONE GROWTH STIMULATOR/BONE FUSION STIMULATOR?

☐ Yes OR ☐ No COCHLEAR, OTOLOGIC, OR OTHER EAR IMPLANT?

☐ Yes OR ☐ No ELECTRONIC IMPLANT OR DEVICE?

☐ Yes OR ☐ No EYELID SPRING OR WIRE?

☐ Yes OR ☐ No HEART VALVE PROSTHESIS?

☐ Yes OR ☐ No IMPLANTED DRUG INFUSION DEVICE? **Will be turned off will need to be checked after exam.**

☐ Yes OR ☐ No INSULIN OR OTHER INFUSION PUMP? **Will be turned off will need to be checked after exam.**

☐ Yes OR ☐ No INTERNAL ELECTRODES OR WIRES?

☐ Yes OR ☐ No MAGNETICALLY-ACTIVATED IMPLANT OR DEVICE?

☐ Yes OR ☐ No METALLIC STENT, FILTER, OR COIL? **Needs to have been implanted six to eight weeks prior.**

☐ Yes OR ☐ No NEUROSTIMULATION SYSTEM?

☐ Yes OR ☐ No PROSTHESIS (EYE, PENILE, ETC.)?

☐ Yes OR ☐ No SPINAL CORD STIMULATOR/WIRES?

☐ Yes OR ☐ No ARTIFICIAL OR PROSTHETIC LIMB?

☐ Yes OR ☐ No BODY PIERCING JEWELRY? **Must be removed Prior to exam.**

☐ Yes OR ☐ No DENTURES OR PARTIAL PLATES?

☐ Yes OR ☐ No HEARING AID? **Must be removed Prior to exam**

☐ Yes OR ☐ No IMPLANTED ORTHOPEDIC ITEMS (PINS,PLATES,SCREWS)?

☐ Yes OR ☐ No IUD, DIAPHRAGM OR PESSARY? **If patient has IUD, it will need to be rechecked after exam.**

☐ Yes OR ☐ No JOINT REPLACEMENT?

☐ Yes OR ☐ No MEDICATION PATCH? **Must be removed, patient to bring another patch to replace.**

☐ Yes OR ☐ No METALLIC FRAGMENT OR FOREIGN BODY?

☐ Yes OR ☐ No OTHER IMPLANT?

☐ Yes OR ☐ No RADIATION SEEDS OR IMPLANTS?

☐ Yes OR ☐ No SHUNT?

☐ Yes OR ☐ No SURGICAL STAPLES, CLIPS OR METALLIC SUTURES? **must be 8 weeks or longer**

☐ Yes OR ☐ No SWAN-GANZ OR THERMODILUTION CATHETER? **Must be removed.**

☐ Yes OR ☐ No TATTOO It is rare but **Some tattoos heat up during scan. Please stay alert during scan**

☐ Yes OR ☐ No PERMANENT EYE MAKEUP? (TATTOO)

☐ Yes OR ☐ No TISSUE EXPANDER?

☐ Yes OR ☐ No VASCULAR ACCESS PORT AND/OR CATHETER?

☐ Yes OR ☐ No WIRE MESH IMPLANT?

☐ Yes OR ☐ No BREATHING PROBLEM OR MOTION DISORDER?

☐ Yes OR ☐ No CLAUSTROPHOBIA? **If patient is claustrophobic, patient must bring sedation and driver, arrive one hour early.**

☐ Yes OR ☐ No DIFFICULTY WITH IV'S?

☐ Yes OR ☐ No HISTORY AS A MACHINIST OR METAL WORKER? **Patient must have eye x-ray if any eye injuries.**

☐ Yes OR ☐ No IF FEMALE, IS PATIENT PREGNANT?**------How many weeks? _____**
(If yes, must be at least 12 weeks pregnant. Must sign pregnancy consent.)

Medication History:

Please list all of the medication you are currently taking including Dose, frequency of prescription and over the counter medications as well as herbal supplements.

Print Patient's Name :

Signature of Patient or Legal Guardian/Rep.

_____ **Date:** _____

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