Today's Date: _____

Patient Name:_____

Name change since last visit? ☐ No ☐ Yes, _____ Sex: F ☐ M ☐ DOB:____/____/____

Street: _____ City: _____ State: _____ Zip: _____

Primary Phone #: _____ Secondary Phone #: _____

Employer: _____ Occupation: _____

Employer Phone #: _____

Emergency Contact: _____ Emergency Contact Phone #: _____

Relationship of Emergency Contact: _____

Person Responsible for Bill, if not Patient

Relationship: _____

Name: _____ Address: _____

_____

Primary Phone #: _____ Phone Type: _____

Insurance (Not Required if Providing Copy of Insurance Card)

Primary: _____ Secondary: _____

Group #: _____ Group #: _____

Member #: _____ Member #: _____

OR

Lien Info: _____ Work Comp Info: _____

_____ _____

We keep a record of your health care services we provided you. You may ask to see and copy that record. You may also ask us to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes and compels us to do so. You may see your record or get more information about it in thisoffice.

If my account is turned over for collections, I agree to assume the responsibility of all collection costs.

Assignment & Release: I hereby authorize that my insurance benefits be paid directly to Greater Missouri Imaging. I am financially responsible for any balances due. I also authorize the Doctor or Insurance Company to release any information required to process this claim. I grant permission to Greater Missouri Imaging to release any information and records regarding today's examination to other healthcare entities involved with my care, for the purpose of aiding in my care.

Signature: _____ Date: _____

GREATER MISSOURI imaging

Safety Screening

Patient safety is our primary concern. The MRI room contains a very strong magnet. Before you are allowed to enter, we must know if you have any metal in/on your body. Please answer the following questions carefully.

Have you ever been a machinist, welder, or metal worker? ----------	No ☐	Yes ☐
Have you ever had a piece of metal removed from your face or eye?	No ☐	Yes ☐
Are you pregnant, possibly pregnant, or breast feeding? ----------	No ☐	Yes ☐

Date of last menstrual period: _____

Do you have any of the below items in/on your body?

Pacemaker, wires, artificial heart valve, or defibrillator? ----------	No ☐	Yes ☐
Brain aneurysm clips? ----------	No ☐	Yes ☐
Ear implant or hearing aids? ----------	No ☐	Yes ☐
Eye implant? ----------	No ☐	Yes ☐
Shunt or electrical stimulator for nerves or bone? ----------	No ☐	Yes ☐
Infusion pump? ----------	No ☐	Yes ☐
Stents, coil filter, or wire in blood vessels? ----------	No ☐	Yes ☐
Implanted catheter or tube? ----------	No ☐	Yes ☐
Orthopedic/Surgical hardware; plates, screws, pins, rods, wires? -----	No ☐	Yes ☐
Artificial limb or joint? ----------	No ☐	Yes ☐
Penile prosthesis? ----------	No ☐	Yes ☐
Magnetic implant anywhere? ----------	No ☐	Yes ☐
Diaphragm or intrauterine device? ----------	No ☐	Yes ☐
False teeth, retainers, or magnetic braces? ----------	No ☐	Yes ☐
Permanent make-up or body piercings? ----------	No ☐	Yes ☐
Metal shrapnel, fragments, bullets, pellets, BBs? ----------	No ☐	Yes ☐
Medicinal patch; birth control, nicotine, pain, etc.? ----------	No ☐	Yes ☐

_____
Supervising Technologist

Describe pain/problem and mark area on body: _____

_____

_____

How did your pain/problem start? _____

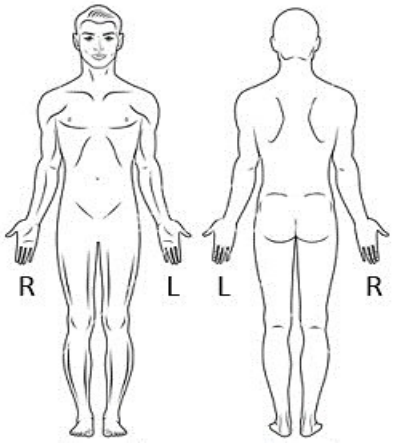
_____

When did your pain/problem start? _____

Approximate Weight (lbs.) _____

Any previous surgery on or around the area we are imaging? ---------- No ☐ Yes ☐

If yes, type of procedure: _____



I attest that the answers I have provided on this form are correct to the best of my knowledge. I have read and understand the entire contents of this form and have had the opportunity to ask questions regarding the information of this form.

Signature: _____ Date: _____

GREATER MISSOURI imaging

Contrast Injection

Your physician has referred you to us for an MRI exam involving an injection of gadolinium based contrast. This contrast may be beneficial in aiding the radiologist to interpret your images. We are prepared to treat any adverse reaction should it occur. Your physician is aware of the remote possibility of a complication and feels that the diagnostic information obtained far outweighs the minimal risk of the procedure.

For people with severely reduced kidney function, gadolinium contrast is considered a possible cause of a rare disease called Nephrogenic Systemic Fibrosis (NSF). It is suggested that patients who receive hemodialysis treatment for renal failure should schedule their hemodialysis for 2-4 hours after gadolinium contrast injection. If you have renal failure, but do not need dialysis, please tell the MRI Tech.

Have you ever had an allergic reaction to contrast? ---------- No ☐ Yes ☐
If yes, explain: _____

Allergic to any medications? ---------- No ☐ Yes ☐
If yes, explain: _____

Have you ever had any kidney disease, failure, or transplant? ------- No ☐ Yes ☐
If yes, explain: _____

Have you ever had any liver disease, failure, or transplant? ---------- No ☐ Yes ☐
If yes, explain: _____

Dialysis? ----------	No ☐	Yes ☐
Diabetic? ----------	No ☐	Yes ☐
High Blood Pressure?	No ☐	Yes ☐
Multiple Myeloma? ---	No ☐	Yes ☐
Asthma/Emphysema?	No ☐	Yes ☐
Heart Condition? -----	No ☐	Yes ☐

I attest that the answers I have provided on this form are correct to the best of my knowledge. I have read and understand the entire contents of this form and have had the opportunity to ask questions regarding the information of this form.

Signature: _____ Date: _____

GREATER MISSOURI imaging

Payment Policies

Patients or Guardians,

In order to achieve the goal of providing the best possible service to you at the lowest possible cost, we need your assistance and agreement to our payment policies. In almost all cases we will process your claim with your insurance plan. In a few instances we encounter some difficulty in that process and much of what follows deals with those exceptions. While we do not expect any difficulties with your claim, we do have to explain our policy in those instances.

By signing this form, you agree to assign Greater Missouri Imaging, for this visit/exam, any and all health care benefits to which you are entitled under any policy of insurance (hospitalization, major medical, worker's compensation, or any other insurance or benefits plan) and authorize, to the extent permitted by law, payment of those benefits directly to Greater Missouri Imaging. We will protect the privacy of your information and will not use it or disclose it, except in a manner that is permitted by state and federal law.

Your plan may require approval (pre-authorization or "pre-cert") from your referring physician prior to your exam. Usually this must be obtained by your physician's office, although sometimes Greater Missouri Imaging is permitted to obtain this. Greater Missouri Imaging cannot always apprise you if your policy requires pre-authorization; however, we will inform you prior to your exam if pre-authorization was obtained. You should verify what the requirements of your plan are for pre-authorization as they vary widely with insurance companies and even within their different plans and policies. You will be responsible for, and agree to pay, any costs of care that your insurance company determines are not covered (denied) for any reason, whether or not pre-authorization is required or obtained under your insurance policy.

By signing this form, you have been advised that your insurance company may determine, even after they provide pre-authorization for your exam, that the services provided (or to be provided) by Greater Missouri Imaging during your visit are not covered under your policy, and you agree that, if your insurance company determines that any services are not covered, you shall be responsible for, and shall pay for, the cost of any such services.

If you have health care benefits, Greater Missouri Imaging will submit a claim to your insurance company on your behalf. However, you are required, and you agree, to pay at the time of service any required co-payments, co-insurance, and deductibles, as well as charges for services not covered by insurance, outstanding balances, and delinquent accounts.

Greater Missouri Imaging allows more than the legal and customary amount of time after filing a claim to be reimbursed by insurance companies. If Greater Missouri Imaging has not received a response in this amount of time, and in no event more than 100 days of having filed a claim for your exam, we will assume that the exam is not covered and is, therefore, your responsibility. At that time, to the extent permitted by law, we will bill you for the visit charges. Questions regarding non-payment by your insurance company should be directed to your insurance company, not Greater Missouri Imaging, as your coverage or contractual relationship, under your policy is between you and your insurance company and Greater Missouri Imaging is not privileged to intervene. Usually contacting your insurance company directly will solve your issue, although you may need to persist to resolution.

You will be billed for all unpaid balances deemed by Greater Missouri Imaging or your insurance company to be your responsibility. Unless you otherwise request, all bills and other communication forms from Greater Missouri Imaging will be sent to your address of record at Greater Missouri Imaging and will be in the name of the patient/guarantor who initially established your account. You are responsible for notifying us if you wish for a different address or name to be used. You are responsible for paying the bill in full unless special agreements have been approved in advance. There is a fee of $25 for returned checks, or the maximum state rate if less. Delinquent accounts will be turned over to a collection agency at which time you will be responsible for collection charges and all associated legal fees in addition to the amount owed.

*A Guarantor is the individual who accepts financial responsibility for services rendered to the patient. The Guarantor may be the patient, family member, or a non-family member. In the event that the patient is a minor or legally dependent person, then the Guarantor must have the authority to take action on the patient's behalf. By signing this form as "Guarantor" on behalf of a minor or legally dependent person, you represent to Greater Missouri Imaging that you have such authority. The term "you" and "your" as used in this document mean the patient's Guarantor.

I have read, understand, and agree to the payment policies described above.

Signature: _____ Date: _____

GREATER MISSOURI imaging

Medical Record Release

Patient Name: _____

DOB:_____ Phone #: _____

Guardian Name: _____
(If applicable)
Relationship: _____

Phone #: _____

I authorize Greater Missouri Imaging to release my health information to the following

(**Other than your referring physician**):

Name: _____ Name: _____

Address: _____ Address: _____

_____ _____

Phone #: _____ Phone #: _____

Fax #: _____ Fax #: _____

I understand that I have the right to revoke this authorization at any time by notifying Greater Missouri Imaging. I understand that the revocation is only effective after it is received by Greater Missouri Imaging. I understand that any use or disclosure of the information under this authorization made prior to the effective date of the revocation will not be affected by the revocation.

I understand that after this information is disclosed, state or federal law might not protect it and the recipient might re-disclose it.

Imaging results are provided to your physician for review prior to their release. Please contact your physician for a copy of your results.

Signature: _____ Date: _____

GREATER MISSOURI imaging