Affordable Medical Imaging Patient Registration Form

PATIENT INFORMATION:

Patient's Name:

_____
Last First MI

DOB: _____ Age: ____ Height (in): _____ Weight (lbs): _____ Gender: Male Female
(MM/DD/YYYY) (circle gender)

Address: _____

City: _____ State: _____ Zip Code: _____

Email: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

EMERGENCY CONTACT INFORMATION: HOW DID YOU HEAR ABOUT US? (Please circle your response)

Name: _____

Relation: _____

Phone: _____

Internet Newspaper Sign
Phone book Friend/Co-worker TV
Mailing Referring Physician
Radio Other _____

PHYSICIAN INFORMATION:

Referring Physician: _____

Clinic: _____

Phone: _____ Fax: _____

Primary Physician: _____

Clinic: _____

Phone: _____ Fax: _____

INSURANCE INFORMATION:

Provider: _____

Policy Number: _____

HIPAA PRIVACY PRACTICE NOTICE

Affordable Medical Imaging, LLC is required by law to maintain the privacy of, and provide individuals with, a notice of our legal duties and privacy practices with respect to protected health information. I have been informed by Affordable Medical Imaging, LLC of the Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. By signing my name below, I acknowledge that I have received this Notice of Privacy Practices for review and I understand and agree to its terms.

Patient Signature: _____ **Date:** _____

Staff Witness Signature: _____ **Date:** _____

affordable
medical imaging

Payment Authorization Form

We appreciate you selecting Affordable Medical Imaging, LLC for your imaging exam. We will do everything we can to make your experience as comfortable and pleasant as possible. Please let us know if there is anything we can do to better serve your needs.

In order to achieve the goal of providing the best possible service to you at the lowest possible cost, full payment is due when services are rendered. We accept Visa, MasterCard, Discover, American Express and Debit Cards. We do accept checks ($35.00 returned check fee) The cost for a single MRI exam of any kind is $495.00 plus $150.00 for contrast. The cost for CT is $350.00 plus $150.00 for contrast. The cost for a single ultrasound exam of any kind is $250.00. The cost for an Echocardiogram is $495.00. The cost for a Vascular Screening is $100.00.

If you intend to submit your paid receipt for reimbursement from your insurance company, you may need to contact your insurance company prior to having your exam.

Affordable Medical Imaging has partnered up with CareCredit to help with financial assistance. CareCredit application must be approved to use it same day. Please ask an associate for further details.

I, _____hereby authorize Affordable Medical Imaging, LLC to charge a total of $ _____to my credit card or debit card for services rendered.

Signature: _____ Date: _____

OFFICE USE ONLY:

Name on Card: _____

Card Number: _____

Exp Date: _____Card Security Code: _____

Card Zip Code: _____

4424 Aicholtz Road, Suite D • Cincinnati, Ohio 45245 Ph: (513) 753-8000