PATIENT INFORMATION

Last Name, First Name_____

Sex M F

Address _____

_____

Date of Birth _____

Social Security Number _____

Home Phone _____

Cell Phone _____

Work Phone _____

INSURANCE INFORMATION:

Primary Insurance Plan Name _____

Company Name _____

Plan Address _____

Insured Person (who is the subscriber) _____

Relation to Patient _____

Insured Person Date of Birth _____

Card Number _____

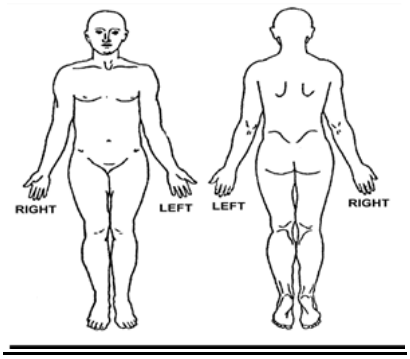
Group Number_____

IMPORTANT: PLEASE PRINT YOUR NAME AND DATE OF BIRTH ON EVERY PAGE

Due to changes in insurance procedures, please fill out this form in detail

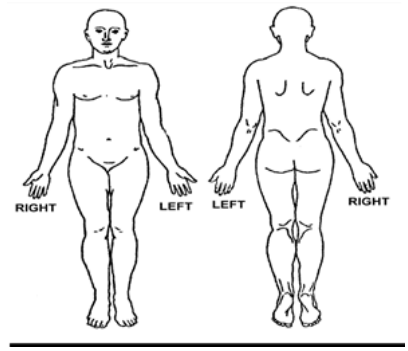
Please answer the questions to the best of your ability and review any questions left unanswered with the technologist

HEIGHT
WEIGHT



Where are you experiencing symptoms? Please mark on the figure. Be specific.

What symptoms are you experiencing? Examples: abdominal pain, diarrhea, nausea, bloating, headache, vision loss



Where is the pain?

Please mark on the figure. Be specific.

What does the pain feel like? Example: Sharp, dull, tender, swollen

When did the symptoms start and how long have you been experiencing them? Ex: last 3 months, last 6 months, 8-4-15,

What treatments have you tried already? Therapy, massage, medicine, rest

Was there an injury, disease, or treatment that caused your symptoms

List ALL/ANY surgeries or operations. If possible, please include when and where you had them.

What active diseases or conditions do you have? Are they currently treating it? How?

Please list all medications that you are currently taking: Use back if necessary

PRINTED NAME: **DATE OF BIRTH:**

RELEASE OF INFORMATION

Please list the Name, Date of Birth, and Relationship for every person you wish to have access to your records.
Please be very careful in choosing who you would like to have access to your records. If no one, draw X over form.
In order to retract this Release of Information, we must have the retraction in written form. This release of information will not expire.

Name	
Date of Birth	
Relationship	
Name	
Date of Birth	
Relationship	
Name	
Date of Birth	
Relationship	
Name	
Date of Birth	
Relationship	
Name	
Date of Birth	
Relationship	

I have had an opportunity to review the privacy and financial policy posted in the waiting area. If I want a copy, I can obtain one from the MDI staff. I understand my information may be shared in coherence with my medical care and insurance with my providers. Other types of release of information must follow the privacy. I hereby authorize the above listed persons to obtain information about my care at MDI.

Patient, Parent or Guardian Signature Date

Patient Name (Please Print)

PRINTED NAME: DATE OF BIRTH:

Medical Diagnostic Imaging of Abilene

4349 S TREADAWAY BLVD | ABILENE TX, 79602 | (325) 695-4624

Financial Responsibility

Thank you for choosing Medical Diagnostic Imaging of Abilene. Our primary mission is to deliver the highest quality care available.

Medical Diagnostic Imaging of Abilene requires payment prior to the beginning of your treatment.

The total patient responsibility is based off of an *estimated* amount after factoring in insurance benefit information available to date.

MDI makes every effort to exhaust all resources available to estimate patient cost as accurately as possible. However, the final determination of your financial responsibility is designated by your insurance carrier and may differ from the estimated amount given at time of service. The patient will be held responsible for the full amount designated as the patient's responsibility by your insurance company. If the patient responsibility is less than estimated a refund will be issued in check form only after all insurances have processed through MDI.

Returned checks will incur a $12 fee and MDI may seek immediate remittance of the returned payment amount from your financial institution.

I hereby authorize payment directly to this Imaging Center of all insurance benefits for services rendered. I understand that I am financially responsible for all charges not covered by insurance for services rendered on my behalf or my dependents. I authorize the above providers to release any information required to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

If you have any questions, please do not hesitate to ask. We are here to help you get the treatment and care you want and need.

Total **ESTIMATED** patient responsibility due today: $_____ **unavailable if printed online. I understand that I am responsible for the estimated amount discussed with me.**

_____ _____

Patient, Parent or Guardian Signature Date

_____ _____

Patient Name (Please Print)

Payment Options: All financial tools must be arranged prior to your appointment.

An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

- Cash, Check, Visa, Mastercard, American Express or Discover Card
  - For patients taking advantage of our private pay rates, a $100 discount per procedure is offered when the amount due is paid in full at time of service.
- Convenient Monthly Payment Plans[1] from CareCredit
  - Allow you to pay over time
  - ***No interest*** if paid in full within designated payment term
  - No annual fees or pre-payment penalties
  - 15 minutes or less to apply and receive approval determination
- In-house payment arrangements
  - Requires a deposit paid at time of service in the amount of 60% of total charges
  - Post-dated payments are automatically processed using payment information provided by the patient. Acceptable forms of payment information is post-dated checks and/or credit/debit card number.
  - Returned check fee $12. Declined credit/debit card transactions will continue to be processed until payment is satisfied.

[1]Subject to credit approval

PRINTED NAME: _____ **DATE OF BIRTH:** _____

Have you ever had an MRI or CT before?

What body part was your previous MRI or CT of?

Where was your previous MRI or CT done?

PRINTED NAME: **DATE OF BIRTH:**