WASATCH IMAGING CENTER, LLC
Magnetic Resonance Imaging

Date _____ Account Number _____

Please complete and return this form to the receptionist as soon as possible. We will file with your insurance company if you provide us with complete insurance information.

PATIENT INFORMATION

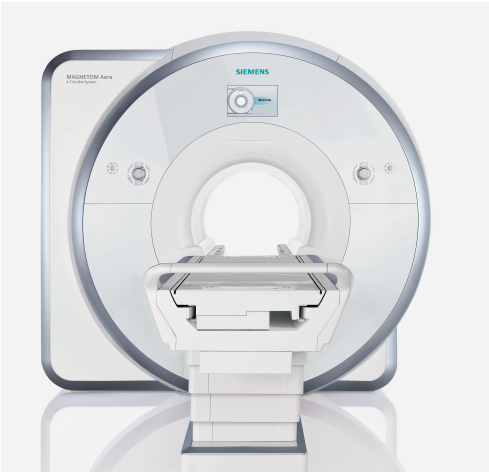
Patient's Name (First, Middle, Last)			
Patient's Address			
City, State			Zip
Date of Birth	Age	Sex	Social Security Number
Marital Status	Home Phone		Cell Phone
Are you ☐ Actively Employed ☐ Retired ☐ Unemployed			
Employer	Work Phone		
Employer's Address (Street)			
City, State			Zip
Occupation (indicate if Student)			

SPOUSE INFORMATION

Spouse Name	
Date of Birth	Phone Number

EMERGENCY CONTACT

Name	
Address	Phone



INSURANCE INFORMATION

PRIMARY INSURANCE*	**Insured Date of Birth**
Name of Insured	
Policy Number	Group Number
Insurance Address (Street)	Phone
City, State	Zip
Claim Adjuster's Name	
SECONDARY INSURANCE*	**Insured Date of Birth**
Name of Policy Holder	
Policy Number	Group Number
Insurance Address (Street)	Phone
City, State	Zip

INJURY INFORMATION

Date of Injury/Illness	Work Related ☐Yes ☐No	Auto Related ☐Yes ☐No
Description L or R		
Are you presently working? ☐Yes ☐No If No date last worked.		

IF PATIENT IS A MINOR

Father's Name (First, Middle, Last)		
Date of Birth	Social Security Number	
Employer		Employer's Phone
Employer's Address (Street)		
City, State		Zip
Mother's Name (First, Middle, Last)		
Date of Birth	Social Security Number	
Employer		Employer's Phone
Employer's Address (Street)		
City, State		Zip

*Medicare is considered to be a primary insurance carrier only if patient is over 65 years of age, is retired, and does not receive health care benefits through a previous employer or spouse's employer.

FINANCIAL AGREEMENT, AUTHORIZATION, ASSIGNMENT OF BENEFITS AND PATIENT CONSENT FORM

With the execution of this document, the undersigned in consideration for services rendered or to be rendered, hereby agrees to the following**:**

1**. FINANCIAL AGREEMENT:** I agree to pay for all services rendered to me by **WASATCH Imaging LLC (**MRI Center). I also agree to pay for all services rendered to me by **MOUNTAIN MEDICAL** for their physician who will be reading my MRI films. I understand that as a courtesy to patients providing insurance/billing information, the MRI Center and Mountain Medical will submit claims to their health care plan or insurance company. However, I further understand that I am responsible for payment of the balance owed. I agree that I am also responsible for any co-pay, deductible, co-insurance, charges for non-covered services, charges for services deemed medically unnecessary, or charges for which a properly authorized written referral, or pre-authorization for the services, was not obtained and is required by my health care plan. In the event that I am not currently enrolled as a member of a health care plan, I am personally responsible for all charges incurred for services. These fees are due at the time services are rendered. Should the account be referred to an attorney, or collection company, the undersigned shall pay all attorney fees and collection expenses, in addition to a collection fee of up to 40% of the principal balance due, as allowed by Utah Code Annotated, sec. 12-1-11. Checks returned by the bank will be charged a $20.00 fee. The terms of this paragraph shall apply to all amounts incurred by me or by any individual for whom I have legal responsibility whether such amounts are incurred today or after today.

2. **MEDICARE AUTHORIZATION:** I request that payment of authorized Medicare benefits due me, be paid on my behalf to the MRI Center and MOUNTAIN MEDICAL, for any services furnished to me by the MRI Center. I authorize any holder of medical or other information about me, to release to any insurance carrier or to the Health Care Financing Administration and its agents, information needed to determine these benefits or any benefits for related services. I permit a copy of this authorization to be used in place of the original. I understand that I am responsible for the Medicare Part B deductible, and the remaining co-insurance charges.

3. **ASSIGNMENT OF BENEFITS:** I hereby assign to the MRI Center and MOUNTAIN MEDICAL those insurance benefit payments due the MRI Center and MOUNTAIN MEDICAL and hereby authorize my insurance company to make payment directly to the MRI Center and MOUNTAIN MEDICAL. I understand that regardless of this assignment, I remain primarily responsible to the MRI Center and MOUNTAIN MEDICAL for payment of all actual charges incurred. A copy of this assignment shall be as valid as the original.

4. **PATIENT CONSENT:** Based on my physician's referral for MRI services, I request and give consent to the MRI Center and MOUNTAIN MEDICAL, their physicians and staff to provide Magnetic Resonance Imaging (MRI) services and related care. This includes any life threatening condition which may arise during the course of my MRI examination or while present at the MRI Center.

5. **WORKERS COMP PATIENTS:** Utah law requires us to release your Medical Records requested by the Labor Commission, your employer, insurance carrier or third party administrator. These requests do not need to confirm to the HIPAA requirements outlined in 45 CFR 164.501. We will release records without a signed release from you.

6. **TEXT:** I authorize Wasatch Imaging to text any phone number on file, for reminders, financial information, questions or notices of any kind. _____ (initial)

My signature acknowledges that I have been given the opportunity to read, or have had the above information explained, and that I fully understand the statements in this document and consent to each of them. I certify that I am the patient or am duly authorized by the patient to execute the above and accept the terms.

_____ _____

Patient Signature Date

WASATCH IMAGING CENTER, LLC
Magnetic Resonance Imaging

How we use and disclose your Protected Health Information. (HIPAA)

1. For Treatment – ours and other health care providers
2. For Payment
3. For Health Care Operations – (example, we may call to remind you of your appointment, and we may leave a message.)

Disclosures with Authorization.

For disclosures not involving treatment, payment, operations or when required or permitted by law, we will need a signed authorization from the patient.

Disclosures without Authorization.

We may disclose your Health Information in the following situations without your consent: Our Business Associates , Family or Close Friend responsible for your care, Required by law, Public Health Activities, Health oversight Activities, Judicial and Administrative Proceedings, Law Enforcement, Research, Victims of Abuse, Neglect or Domestic Violence, Limited Government Functions, Coroners, Medical Examiners and Funeral Directors, Health and Safety of public, Workers Compensation.

Your Rights.

Right to receive a copy of this notice. A detailed copy is available to you to read or to have. Located on the front counter.

Right to contact our Privacy Officer

Right to inspect and receive a copy of your health information

Right to amend your health information

Right to request additional restrictions on uses and disclosures of your health information

Right to request an accounting of disclosures

Right to request confidentiality in certain communications

Right to file a complaint

Right to revoke this consent in writing

I have read your Privacy Practices Policy.

_____	_____	_____
Signature	Date	Witness

People here with you: _____

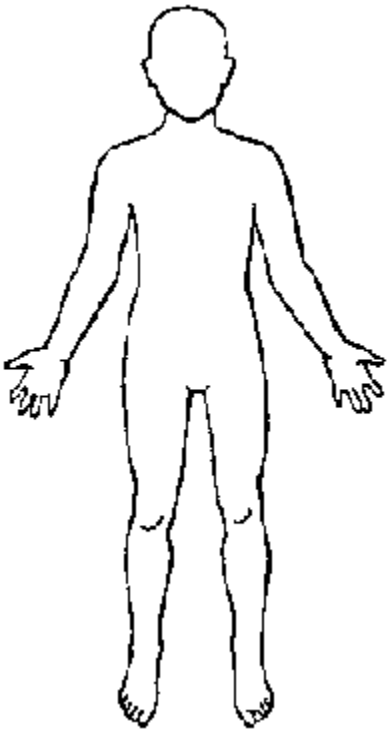
WASATCH IMAGING CENTER, LLC
Magnetic Resonance Imaging

Warning: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure. **DO NOT ENTER** the MR environment or MR room if you have any questions or concern regarding an implant, device of object. Consult the MRI Technologist BEFORE entering the MR room. The MR system magnet is always on.

Please indicate if you have any of the following:

○ Yes	○ No	1.	Aneurysm clip(s)
○ Yes	○ No	2.	Cardiac pacemaker
○ Yes	○ No	3.	Implanted cardioverter defibrillator (ICD)
○ Yes	○ No	4.	Electronic implant or device
○ Yes	○ No	5.	Magnetically-activated implant/device
○ Yes	○ No	6.	Neurostimulation system
○ Yes	○ No	7.	Spinal cord simulator
○ Yes	○ No	8.	Internal electrodes or wires
○ Yes	○ No	9.	Bone growth/bone fusion stimulator
○ Yes	○ No	10.	Cochlear, otologic, or other ear implant
○ Yes	○ No	11.	Insulin or other infusion pumps
○ Yes	○ No	12.	Implanted drug infusion device
○ Yes	○ No	13.	Any type of prosthesis (eye, penile, etc.)
○ Yes	○ No	14.	Heart valve prosthesis
○ Yes	○ No	15.	Eyelid spring or wire
○ Yes	○ No	16.	Artificial or prosthetic limb
○ Yes	○ No	17.	Metallic stent, filter or coil
○ Yes	○ No	18.	Shunt (spinal or intraventricular)
○ Yes	○ No	19.	Vascular access port and/or catheter
○ Yes	○ No	20.	Radiation seeds or implants
○ Yes	○ No	21.	Swan-Ganz or thermo dilution catheter
○ Yes	○ No	22.	Medication patch (Nicotine, Nitroglycerine, etc.)
○ Yes	○ No	23.	Any metallic fragment or foreign body
○ Yes	○ No	24.	Injury with metal (in eyes, skin, etc.)
○ Yes	○ No	25.	Wire mesh implant
○ Yes	○ No	26.	Breast Reconstruction
○ Yes	○ No	27.	Surgical staples, clips, or metallic sutures
○ Yes	○ No	28.	Joint replacement (hip, knee, etc.)
○ Yes	○ No	29.	Bone/joint pin, screw, nail, wire, plate, etc.
○ Yes	○ No	30.	IUD, diaphragm, or pessary
○ Yes	○ No	31.	Hair extensions
○ Yes	○ No	32.	Dentures or partial plates
○ Yes	○ No	33.	Tattoo or permanent makeup
○ Yes	○ No	34.	Body piercing jewelry (ears, belly button, etc.)
○ Yes	○ No	35.	Hearing aid (remove before entering MR room)
○ Yes	○ No	36.	Other implant _____
○ Yes	○ No	37.	Breathing problem or motion disorder
○ Yes	○ No	38.	Claustrophobia
○ Yes	○ No	39.	Have you had any surgeries in the last 8 weeks?
○ Yes	○ No	40.	Are you pregnant or breastfeeding?
○ Yes	○ No	41.	Have you ever had a reaction to MRI contrast?

If you marked "yes" on any of the questions to the left please indicate the location of the object on the diagram below.



I attest that the above information is correct to the best of my knowledge. I read and understand the contents of this form and had the opportunity to ask questions regarding the information it contains. I was also given the opportunity to ask question regarding the MR procedure that I am about to undergo.

Signature of Patient or Guardian_____ Date _____

Please print Patient Name_____

Technologist that reviewed this form: _____