Southlake MRI & Diagnostic Center

One Cambridge Square •108 East 90th Dr.• Merrillville, IN 46410
Tel: (219) 795-1801• Fax: (219) 795-1802

PATIENT INFORMATION:		CDS:
Name		
Address		
City	State	Zip
Home Phone	Alternate Phone	
Single □ Married □ Domestic Partner □	**Social Security #**	
Date of Birth Male □ Female □	Referring Physician	
Patient Employer	Employer Phone	
IN CASE OF AN EMERGENCY:		
Contact Name	Relationship to Patient	
Phone	Alternate Phone	
INSURANCE INFORMATION:		
PRIMARY POLICY HOLDERS NAME		
Date of Birth	SS#	
Employer	Employer Phone	
SECONDARY POLICY HOLDERS NAME		
Date of Birth	SS#	
Employer	Employer Phone	
√ if Work Related □ ***Date of Injury_____***	**√ if Auto Accident □** ***Date of Accident_____***	
√ if Patient is under 18 years of age □		
IF PATIENT IS A MINOR, PLEASE COMPLETE THIS SECTION:		
Responsible Party Name		
Address		
City	State	Zip
Home Phone	Relationship to Patient	

CONSENT AND AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS. I GIVE PERMISSION TO SOUTHLAKE MRI & DIAGNOSTIC CENTER TO RELEASE MY MEDICAL RECORD (IMAGES/REPORT TO:

PLEASE INDICATE BELOW IF YOU WOULD LIKE SOMEONE OTHER THAN YOURSELF TO PICK UP YOUR MEDICAL RECORDS *** PHYSICIANS DO NOT NEED PERMISSION***

Name Relationship to Patient

Name Relationship to Patient

**** PLEASE CONTINUE ON THE BACK SIDE OF THIS PAPER****

PLEASE READ AND SIGN BELOW

CONSENT AND AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize the release of any medical information necessary to process this claim. I certify that the information I have reported with regard to my insurance coverage is correct. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing. I also hereby authorize and consent to the giving of all treatments, examinations and any technical procedures which in the judgment of the staff of Southlake MRI are considered necessary or advisable for diagnosis and treatment.

I authorize the release of any medical information necessary to process claims for services rendered to myself or the minor patient.

I authorize Southlake MRI & Diagnostic Center LLC to submit claims for payment to my medical insurance(s), if applicable, and / or to apply for benefits on my behalf for covered services rendered by this facility. I request that payment from my insurance company (ies) be made directly to Southlake MRI & Diagnostic Center LLC (or to the party that accepts assignment).

I understand that I am legally responsible for payment for services rendered. I hereby agree to be held liable for payment of such. I agree to pay any balance, including co-payments, deductibles and co-insurance, within 30 days of receiving a bill for services. I agree to be responsible for any and all collection fees, including attorney's fees, if my account becomes delinquent and is referred to a collection agency.

Payment in full is expected within 30 days of receiving a bill or statement. Any other payment arrangement must be determined in advance and approved by the office manager or other authorized person.

I understand that I am responsible for any authorizations or referrals required by my managed care insurance policy, if applicable. I agree to be financially responsible for payment for services rendered if I fail to obtain necessary authorizations or referrals.

I agree that it is my responsibility to verify facility participation in managed care organizations. I understand that I may be responsible for higher out-of-pocket expenses if I receive treatment from a non-participating facility. I understand that if Southlake MRI & Diagnostic Center LLC is determined to be a non-participating facility with my insurance carrier(s), the facility may adjust any coinsurance and deductible amounts to reflect in-network benefit levels.

Acknowledgement of Receipt of Notice of Privacy Practices

Your name and signature on this sheet indicate that you have been given the opportunity to review and request a copy of Southlake MRI & Diagnostic Center's Notice of Privacy Practices (Notice) on the date indicated. If you have any questions regarding the information in Southlake MRI and Diagnostic Center's Notice of Privacy Practices, please do not hesitate to contact a clinic representative or the Southlake MRI and Diagnostic Center Patient Privacy Officer as indicated on your Notice.

I GIVE PERMISSION TO Southlake MRI & Diagnostic Center TO LEAVE A MESSAGE ON MY VOICEMAIL/ANSWERING MACHINE.
Please notify the front desk staff if you DO NOT want a message left on your voicemail/answering machine.

SELF-PAY ACCOUNT PATIENTS ONLY. *Please select one of the following options:*

I understand that if I choose to register as a "cash account", Southlake MRI & Diagnostic Center LLC will not file a claim for insurance benefits and / or authorizations for my services. I agree that I understand that Southlake MRI & Diagnostic Center LLC will not adjust charges per any participating provider contracts if I withhold my insurance information prior to services being rendered. I acknowledge that a denial for lack of authorization by my insurance company does not release me from financial responsibility for my service(s) if I fail to disclose insurance coverage prior to services being rendered.

□ I DO NOT HAVE INSURANCE COVERAGE **□ I CHOOSE NOT TO DISCLOSE MY INSURANCE COVERAGE**

ALL PATIENTS MUST PRINT AND SIGN BELOW

Patient's Name **PLEASE PRINT** Date of Birth

Patient's Signature or Legal Representative's Signature Date

Southlake MRI Staff Member Date