Patient Name:_____ DOB:_____

PLEASE READ AND INITIAL THE FOLLOWING:

_____ **CONSENT FOR MEDICAL TREATMENT:** I authorize the above referenced center to furnish the necessary medical procedure that has been ordered by my physician. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of diagnostic procedures in the above referenced center. I recognize that the physicians who practice at the Center are not employees of the above referenced center, but are independent physicians. The above referenced center may delegate to these independent physicians those services physicians normally provide. Any questions related to my care should be directed to my physician.

_____ **ASSIGNMENT OF BENEFITS:** I hereby authorize payment directly to the above referenced center of any and all medical benefits applicable and otherwise payable to me. I understand that I am financially responsible to the Center for charges not covered by this assignment. I also understand that the Center is filing my claim as a courtesy to me and that unless stipulated in a contract with my carrier, I am responsible for payment of this claim.

_____ **AUTHORIZATION FOR RELEASE OF INFORMATION:** I hereby authorize the above referenced center to release any information requested by the insurance company necessary to collect benefits on this claim. Unless noted below, this authorization includes, but is not limited to, the release of information related to drug, alcohol, HIV antibody and/or psychiatric testing. I further authorize any physician or institution that attended this patient previously to furnish medical records or information that may be requested by the above referenced center.

_____ **MEDICARE B SIGNATURE AUTHORIZATION:** I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers, or to the billing agent of the Center, any information needed for this claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical benefits to be made to the holder of this assignment on my behalf. I understand that I am responsible for any health deductibles and co-insurance.

_____ **WORKER'S COMPENSATION:** I authorize the above referenced center to furnish written reports of my procedure to any representative, attorney for, or investigator from my Worker's Compensation carrier concerning injuries sustained as a result of accident occurring on _____/_____/_____.

_____ **IF PATIENT IS A MINOR:** I hereby give permission for _____ to be treated at the above referenced center.

_____ **HIPAA NOTICE OF PRIVACY:** I have read the notice of privacy practice of the above referenced center.

_____ **PERSONAL BELONGINGS:** I am personally responsible for my belongings and/or valuables that I have with me in the locker/dressing room or exam room. I will personally make sure I have everything with me before I leave the premises.

_____ **TRICARE/CHAMPUS PATIENTS:** I understand that Tricare is secondary to other insurance plans except for Medicaid and Tricare supplement plans. I agree to provide the above referenced center with all insurance plans that I am currently enrolled so that benefits can be coordinated and the appropriate authorizations can be obtained. I understand that failure to provide correct and accurate information may result in the patient in being responsible for entire balance.

NOTE: I understand that different Payers/Health Plans have different requirements for payment including, but not limited to pre-certification, authorizations, or notifications, timely filing of claims, or that the services be medically necessary as defined by the health plan. I understand that verification of benefits from Patient's Insurance Company is not a guarantee that services are covered or will be paid by the Insurance Company. I also understand that it is MY obligation to know the requirements of my health plan and ensure that they have been fulfilled.

If you did not provide your insurance information today, or if it is not accurate, then you may be obligated to make full payment of all charges. It will be your responsibility to file the claim with your insurance provider. If you provided us insurance information today, you are obligated to pay all co-payments, deductibles, and any non-covered out-of-network/reduced benefits at the time the services are rendered. You have an affirmative duty to make sure that payment and/or correct information for payment is given to the above referenced center for reimbursement of services provided. Be advised there will be a fee of $45 for any returned check.

X_____ _____

Patient/Guardian Signature Date

Patient Demographics

Name:_____ DOB:_____ SS#:_____

Address:_____
PO Box or Street Address City State Zip Code

Phone Numbers: Home:_____ Cell:_____

Email Address:_____

How would you like for us to contact you? ❑Phone ❑Email

Gender: ❑Male ❑Female Marital Status: ❑Single ❑Married ❑Divorced ❑Widowed ❑Separated

Primary Language:
❑English ❑Spanish ❑Other:_____

Race: (please check all that apply)
❑White ❑Black or African American ❑Asian ❑Refused
❑American Indian or Alaska Native ❑Native Hawaiian or Other Pacific Islander

Ethnicity:
❑Hispanic or Latino ❑Not Hispanic or Latino ❑Refused

Employer Information

Company Name:_____ Work#:_____

Address:_____
Street Address City State Zip Code

Insurance Information

Primary Insurance

Insured Name:_____

DOB: _____

Secondary Insurance

Insured Name:_____

DOB: _____

Emergency Contact(s)

Name:_____

Relationship:_____

Phone Number:_____

Name:_____

Relationship:_____

Phone Number:_____

Is your visit today related to an injury or accident? ❑Yes ❑No
(If yes please complete section below)
Injury due to: ❑Work ❑Auto ❑Trauma ❑Slip/Fall
Date of Injury:_____ Time of Injury:_____
Location of Injury: examples (home, skiing, walking, etc.)_____
What part of your body was injured?(be specific)_____
Have you been receiving treatment for this injury? ❑Yes ❑No
If yes, who is the doctor treating you for the injury?_____

Patient Signature X:_____ Date:_____

RECORD RELEASE

Griffin Imaging and Griffin Open MRI Phone: 770-229-4660 Fax: 770-229-4632

220 Rock Street Griffin, GA 30224

I hereby request and authorize Griffin Imaging/Griffin Open MRI to obtain copies of my medical records and/or images from _____.

Patient Name: _____

Date of Birth: _____

Exam: _____

Date of Service: _____

I hereby request and authorize Griffin Imaging/Griffin Open MRI to release my images and/or report to any HIPAA compliant facility (hospital, physician, etc.) that requests a copy unless otherwise notified not to release records in writing.

*By signing this form, it will save time and an additional required signature by you or your physician to release the records and images should you be referred to another physician or hospital.

Patient Signature: _____

Date: _____

Witness: _____

Date: _____