WINDHAVEN
MEDICAL IMAGING
3T MRI CT SCAN

Patient Consent Form

Patient Name: _____
Last Legal First Middle

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Sex: _____ SS# _____ Home Phone: _____

Work Phone: _____Mobile Phone: _____

Emergency Contact: _____Phone: _____

Referring Physician: _____ Insured Name/DOB_____

Was this due to an accident _____ Work related _____ Auto _____ Accident Date _____

Insurance Name: _____ID#: _____ Group#:_____

I hereby consent to such procedures as may be performed by WMI which are rendered under the instructions of my referring physician.

- I understand and specifically agree that WMI may release any medical information compiled in my medical records to any organization that is or may be liable or responsible for payment of charges associated with the imaging or other procedures performed by WMI and for all other purposes of payment of claims. I further authorize WMI to release and/or use my health care information for the purpose of treatment, payment or health care operations. _____ Initial

  By signing this acknowledgement I realize that I may receive a split bill for the exam – with the first part being for the Technical (scan) portion and a separate bill for the Professional (Radiologist Reading of the scan) from one of the following Radiology reading groups: 1) Texas Neuroradiology Associates (TNR) or 2) Texas Radiology Associates (TRA) – _____ Initial

- I assign to WMI/TNR/TRA all benefits payable for the services rendered at WMI, which are provided in any and all insurance policies and health benefit plans from which my dependents or I are entitled to recover. I understand that I am responsible for any health insurance deductibles, copayments, and coinsurance. I have read and been given the opportunity to ask questions about this assignment of benefits, and I have signed this document freely. I understand that if my insurance company or health benefit plan does not make payment, I will be responsible for any and all charges. I agree, whether I sign as a parent, guardian, agent, spouse, guarantor or patient, that in consideration for the services rendered, I individually obligate myself to pay WMI/TNR/TRA for all services provided by WMI/TNR/TRA in accordance with the regular rates and terms of WMI/TNR/TRA. _____ Initial

PAYMENTS: Any amount due today is based on a review of benefits provided to us by your insurance company. This is only a quote and not a verification of benefits. The percentage not covered is calculated from an estimated contract amount from your insurance company. This is only an ESTIMATE and you may receive a bill/refund in the mail after your insurance has paid the claim.

FILMS/CD's: When you have a diagnostic test (including MRI.CT, or x-ray) at WMI your films will be sent to your referring physician. Should you decide to take the films with you then you assume the legal responsibility for their care. If for any reason you need additional images you need to call 24 hours in advance to request them. We do charge $25.00 per CD and $12.00 a sheet for films.

- I have been given the opportunity to read or receive a copy of WMI's Notice of Privacy Practices explaining uses and disclosures of protected health information.

I hereby certify that I have read and that I fully and completely understand the foregoing.

Patient/Guarantor Signature: _____ Date: _____