Exam Date:					
Pt. Id#		**SS#** :		**Ins to be billed** :	
Pt.Name : **Phone :** **Email Address:**				**Insurance** : **Policy #** : Address	
DOB: Age: Gender :				**Secondary Ins:** **Policy#:**	
Access of records by others/name: **Can we leave a message on your VM**:				Address	
Emergency Contact Name: **Emergency Contact Phone:**				**Exam Desc** :	
				Ord Phys : **Ord Phone #**	
If WORKERS COMP: Date of Injury **Employer** at time of injury: **Address**:					

INSURANCE WAIVER

PHYSICIAN NOTICE:..

Your insurance will only pay for services that it deems "reasonable and necessary". If your insurance carrier determines that a particular service is not "reasonable and necessary" by your private physician, they will deny payment. Further, if your service requires pre-authorization or a referral and you fail to provide the same, your insurance will deny payment.

Therefore, you must agree in advance of this service that should your insurance carrier fail to pay for this service, which was ordered in good faith, you will be totally responsible for payment.

ASSIGNMENT OF BENEFITS:

I hereby assign, transfer and/or set over sufficient monies and/or benefits to which I may be entitled from government agencies, insurance carriers and others liable for my healthcare to cover the costs of care rendered to me or my dependent, and I hereby authorize payment directly to the physician.

BENEFICIARY AGREEMENT:

I have been notified by WNY MRI staff that should my insurance carrier fail to pay or denies payment, I agree to be personally and fully responsible for payment.

I confirm that all statements/information above is accurate and complete:

Privacy Policy (HIPAA)offered: YES

Signature of Patient: