Premier MRI CT

Account # _____

Date_____

PERSONAL INFORMATION

Name (Please Print)	First	Middle Initial	Last			Date of Birth	Age
SSN					Female ☐	Male ☐	
Address							
City			State		Zip code		
Phone	Home:		Work:		Cell:		
Emergency Contact					Phone		

PHYSICIAN INFORMATION

Ordering Physician:	(MD/DO/DC/DPM/DDS)
Address and Phone:	( )
Is there another doctor who should receive a copy of the report? If so, please provide info below:	
Name:	( )
Address:	

INSURANCE INFORMATION

Primary Medical Insurance				Effective Date	
Policy Number				Group Number	
Insurance provided through:	Your employer ☐	Spouse's employer ☐	Other ☐		
If other than self, list information for the primary card holder:					
Name		SS#		Date of Birth	
Employer name					

Second Medical Insurance				Effective Date	
Policy Number				Group Number	
Insurance provided through:	Your employer ☐	Spouse's employer ☐	Other ☐		
If other than self, list information for the primary card holder:					
Name		SS#		Date of Birth	
Employer name					

Patient Signature _____ or Signature of patient's representative_____

(Relationship: __ Parent (minor under 18 years) __Court appointed Guardian)

Date _____

Please complete the information below if the injury is related to Work, Auto or Other known injury.

Is this a WORK related injury?		Yes ☐	No ☐	
If yes:	Date of injury:			
Employer you worked for when injured:				

Is this an AUTO related injury?		Yes ☐	No ☐	
If yes:	Date of injury:			

Is this another type injury?		Yes ☐	No ☐	
If yes:	Date of injury:			
Where did injury take place?				
How were you injured?				

Claim number:					
Send bills to:			Caseworker:		
Insurance			Name		
Address			Address		
City			City		
State		Zip	State		Zip
Adjuster			Phone	( )	
Phone	( )				

Is there a lawsuit involved?	Yes ☐	No ☐	

IF yes, please provide attorney information

Name	
Address	
Phone	( )

MICHIGAN HEAD & SPINE INSTITUTE

29275 Northwestern Hwy, Suite 100
Southfield, Michigan, 48034
Phone: 877-784-3667 Fax: 248-784-3678

PAYMENT POLICY

Payment for services provided by Michigan Head & Spine Institute, PC. are your responsibility. As a courtesy to our patients, we will bill most insurance plans for services provided. However, in order to receive payment from the insurance company, both you and Michigan Head & Spine Institute, PC, are required to follow the rules of that company. Please let us know of any change in your insurance.

ASSIGNMENT OF BENEFITS

I authorize any payments be made to Michigan Head & Spine Institute, PC by my insurance company or carrier or other payor related to medical services provided.

RESPONSIBILITY OF PAYMENT FOR MEDICAL SERVICES

I agree to pay in full any and all charges for medical services provided to me by Michigan Head & Spine Institute, PC not otherwise covered by my Medicare, insurance company or carrier, or other payor.

E-MAIL COMMUNICATIONS

- Some of our patients wish to communicate with physicians and staff via e-mail. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations effective April 14, 2003 require that you have the right to have your Health Information protected. E-mail information can be intercepted and viewed by others that are not known to you or your physician.
- I am aware that it is possible that some of my Health Information may not be protected through e-mail communication.

___Yes, you may communicate with me via e-mail __ No, do not use e-mail to communicate with me

PAYMENT POLICY

- All co-payments / deductibles must be paid on your scheduled visit. Failure to make payment will result in a $10.00 statement fee billed to your account at the end of the month. Elective procedures will not be scheduled prior to payment or payment arrangements. Your account will be considered in default 90 days after it is determined to be a patient's responsibility and if payment arrangements are not made and completed as agreed.
- We will make every attempt possible to collect payment from your insurance for services rendered. Any balance over 45 days old will be transferred to patient responsibility in an effort to settle the balance. You can assist by contacting your insurance company.
- You will receive a total of three statements in effort to collect patient balances. After non-payment or lack of payment arrangements the balance will be sent to collections. There will be a 30% fee charge based on your balance to all accounts sent to collections. This represents what all collection agencies charge.
- Payment requirements for accounts in collections will consist of 50% of outstanding balance to be paid before scheduled visit.
- For patients seeing a Physical Medicine & Rehab physician, there is a $50 charge for all no-shows without a twenty-four hour cancellation notice.
- There will be a $30 charge for all returned checks.
- There is a charge of $25 for completion of every form with the exception of the following:
- Off work or return to work letter for your employer
- Forms for patients on medical assistance (Medicaid or Adult Benefit Waiver Program)
- Charge for a case manager to meet with the physician at the time of the patient's office visit is $25.00, payable prior to office visit. *(This only applies if you have a Case Manager for Worker's Compensation, Auto or with some medical insurances.)*
- This assignment can not be voided or withdrawn until account is paid in full.

Patient Name_____Date of Birth_____SS#_____
(Please Print)

Patient or Parent/Guardian Signature_____Date_____Account #_____
(If guardian, copy of guardianship papers to be attached)

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

The Notice of Privacy Practices provides information about how we may use and disclose protected health information about you.

In addition to the copy we will provide you, copies of the current notice are available at any of our office locations.

☐ I acknowledge that I have received the Notice of Privacy Practices.

☐ I am aware of MHSI privacy policies and am declining a copy.

_____ _____
Signature of Patient or Patient's Representative Date

_____ _____
Print Name Relationship to Patient

_____ _____ _____
Patient's Date of Birth Social Security # Account #

____ Notice of Privacy Practices Given-Patient Unable to Sign

____ Notice of Privacy Practices Given-Patient Declined to Sign

____ Other_____

_____ _____
Signature of MHSI Representative Date

_____
Print Name

Please contact our Privacy Official should you have questions concerning this notice.