Lehigh Magnetic Imaging Center

LEHIGH VALLEY HEALTH NETWORK

INSURANCE CONSENT

Patient Name ____
Last First Middle initial

As a courtesy to our patients, Lehigh Magnetic Imaging Center is pleased to submit claims to your primary and secondary health insurances. Please provide all requested information.

Is today's test related to an auto accident or workers' compensation injury? ❑Yes ❑No
If yes, indicate where, when and how injury occurred ____________________________________
____
____
____

INSURANCE AND COORDINATION OF BENEFITS

Patient's Primary Insurance* ____

What is the relationship of the patient to the policyholder (subscriber) of the primary insurance?
❑ Self ❑ Spouse ❑ Child ❑ Other

Please complete the following information

Subscriber's name ______________________________ Subscriber's SSN ____________________

Subscriber's date of birth ____________________ Subscriber's work telephone (_____) _____-____

Subscriber's employer ____

Patient's Secondary Insurance* ____

What is the relationship of the patient to the policyholder (subscriber) of the secondary insurance?
❑ Self ❑ Spouse ❑ Child ❑ Other

Please complete the following information

Subscriber's name ______________________________ Subscriber's SSN ____________________

Subscriber's date of birth ____________________ Subscriber's work telephone (_____) _____-____

Subscriber's employer ____

***Please provide proof of insurance at the time of your visit.**

PAYMENT GUARANTEE AND AUTHORIZATIONS

1. PAYMENT AUTHORIZATION: I hereby authorize my insurer(s) to pay direct to Lehigh Magnetic Imaging Center any insurance benefits due me.

2. PAYMENT GUARANTEE: I hereby guarantee to pay Lehigh Magnetic Imaging Center at the time of service any deductibles, co-insurances or amount that is not covered by my insurance. I understand I will be charged a $20 fee for any check returned for insufficient funds.

   In the event that I fail to make payment as provided above, or as agreed to by prior arrangement with Lehigh Magnetic Imaging Center, I understand affirmative collection measures will be initiated.

3. RELEASE OF MEDICAL INFORMATION: I hereby authorize Lehigh Magnetic Imaging Center to release medical information to: (a) my insurer(s); (b) legal representative(s); (c) Lehigh Valley Health Network computerized patient information system; or (d) my health care providers.

4. ACKNOWLEDGMENT AND CONSENT: I have been referred to Lehigh Magnetic Imaging Center by my treating physician for the performance of a magnetic resonance imaging study. I acknowledge that the necessity for this study has been explained to me by my physician. I understand that in some cases an intravenous injection of a contrast agent may be recommended. Based upon the information provided, I consent to have the MRI study performed at Lehigh Magnetic Imaging Center. I further authorize Lehigh Magnetic Imaging Center to obtain those medical records necessary for interpretation of, or correlation with, the study.

5. HIPAA POLICY: Lehigh Magnetic Imaging Center will provide upon request the Health Information Privacy Notice for Lehigh Valley Health Network and the Common Medical Staff of Lehigh Valley Health Network and Lehigh Valley Health Network-Muhlenberg.

6. FOR MEDICARE PATIENTS ONLY: I request that payment of authorized Medicare benefits be made either to me or on my behalf to Lehigh Magnetic Imaging Center for any services furnished to me. I authorize any holder of Medicare information about me to release to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand and agree to all terms and conditions.

Patient Name (print) ____

Patient or authorized signature _____________________________________ Date ____ / _____ / _____

Name and relationship if other than patient__________________________________ ____________

Print name Relationship

Lehigh Magnetic Imaging Center use only

Identity verified by _____________________________________ Date______ / ______ /_______