NWR
NorthwestRadiologyNetwork
"Trusted Imaging Since 1967"

COMPREHENSIVE IMAGING SERVICES
High Field Strength Conventional & Open MRI
Nuclear Medicine • Helical CT
ACR Accredited and FDA Certified Mammography Facilities
ACR Accredited Ultrasonography Facilities

Business Office
5756 W. 71st Street
Indianapolis, IN 46278
317.328.5050 • 317.328.5051 FAX
800.400.XRAY (9729)
www.northwestradiology.com

Patient Name ______________________________

Social Security # ______________________________

Address ______________________________

City ______________________ State __________ Zip __________

Home Phone ______________________ Work Phone ______________________

Date of Birth ______________________ Age __________ Sex __________

Whom may we contact in case of emergency?

Name ______________________ Phone ______________________

Name of Primary Insurance ______________________________

Name of Policyholder ______________________ Policyholder's Date of Birth __________

Policyholder's Employer ______________________ Relationship to Patient __________

Name of Secondary Insurance ______________________________

Name of Policyholder ______________________ Policyholder's Date of Birth __________

Policyholder's Employer ______________________ Relationship to Patient __________

Referring Physician______________________________

Symptoms ______________________ Date of Onset or Injury __________

Have you ever been diagnosed with cancer? ______________________________

PLEASE PRESENT YOUR INSURANCE CARD, SO WE MAY PHOTOCOPY IT.

Payment Assignment
I request payment of benefits be made on my behalf for any services furnished to me by Northwest Radiology Network. (Medicare beneficiaries should sign statement on the back of this form.)

Accept Ultimate Financial Responsibility
I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered, including but not limited to collection agency fees and court costs. If after Northwest Radiology Network makes reasonable attempt to collect my balance due, I have not responded by paying my account in full or by arranging for a payment plan, it will be turned over to a collection agency. The additional costs incurred by Northwest Radiology Network for this action will also be passed along to me.

Signature ______________________________ Date __________

CONSENT TO TREAT A MINOR

Patient Name ______________________________

Guardian Name ______________________ **Relationship** ______________________

I, as the parent or lawful guardian of this patient, authorize Northwest Radiology Network to render the ordered exams as well as any unforeseen treatment the staff deems necessary.

Signature ______________________________ Date __________

If you think you may be pregnant, please notify our staff before proceeding with the examination.

NORTHWEST RADIOLOGY NETWORK PATIENT PRIVACY SUMMARY

Effective April 14, 2003

Northwest Radiology Network (NWR) is committed to preserving the privacy of protected health information (PHI). We are required by law to protect your medical information and to provide you with Notice describing:

How Medical Information About You May Be Used and Disclosed, and How You Can Access This Information.

NWR is required by law to have your written Consent before we use or disclose your medical information, for purposes of providing or arranging for your health care, the reimbursement of the care that we provide to you, and the related administrative activities supporting your treatment. Your signature on this Summary acknowledges that you understand the Consent to release PHI arrangement.

As our patient, you have important rights relating to inspecting and copying medical information that we maintain, amending or correcting that information, obtaining an accounting of disclosures of your medical information for which you gave separate Authorization, requesting that we communicate with you confidentially, requesting that we restrict certain uses and disclosures of your health information, and filing a formal complaint if you think your rights have been violated. Your signature below acknowledges that you understand your patient rights in regard to PHI.

NWR may be subpoenaed for records or required by certain laws to use and disclose your medical information, for other purposes without your Consent or Authorization. Examples of such situations are described in the NWR Notice of Privacy Practices.

The Notice of Privacy Practices fully explains your patient rights and NWR obligations under the law. We may revise our Notice from time to time. The effective date for the most current Notice in effect is shown on this Summary.

You have the right to receive a copy of our most current Notice in effect. Please ask a technologist, an office staff employee or a billing staff employee who can provide you with a copy of the Notice.

If you have any questions, concerns, or complaints about the Notice or your medical information, please contact:

Northwest Radiology Network – Privacy Officer
5756 West 71st Street
Indianapolis, Indiana 46278
317-328-5050 or 800-400-XRAY (9729)

Acknowledgement ______________________________ Date ______________

MEDICARE SIGNATURE ON FILE

Name ______________________________ Medicare ID # ______________

“I request payment of authorized Medicare benefits be made to me or on my behalf to Northwest Radiology Network for any services furnished me by Northwest Radiology Network. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.”

Patient Signature ______________________________ Date ______________