UNIVERSITY MRI & Diagnostic Imaging Centers

Patient Last Name: _____ First Name: _____ Initial: _____

Address: _____

City/State/Zip: _____

Home Phone: _____ Cell/Other Phone: _____

Social Security: _____ Date of Birth: _____

E-MAIL ADDRESS: _____

By providing the e-mail address, the patient agrees to receive email communication from either health companion or other personal health record providers.

For office use only

Place label here

Is your insurance a: PPO _ HMO _ OTHER_____

Is your condition related to: Accident _ Yes _ No If yes; _ Employment _ Auto _ Other

I hereby authorize payment of my medical benefits directly to University MRI and the release of any medical information necessary to process my medical claims.

Amt. Received: _____ Payment type: Check #_____ Cash _____ Credit Card _____

Apply to: Co-pay/Deductible_____ NO INSURANCE / Private Pay_____ Prior Balance _____

_____ _____

Patient Signature **UMRI Representative**

Web Form