LEXINGTON DIAGNOSTIC CENTER & OPEN MRI

1 Patient Information

Patient Name (first then last): _____

Date: _____ Patient Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Date of Birth: _____

Social Security Number: _____ Height: _____ Weight: _____

Employer: _____

Emergency Contact: _____ Phone: _____

E-Mail Address: _____ (For Access to Patient Portal)

☐ I decline access to the Patient Portal at this time

Who is the healthcare provider that referred you to see us today?

Race (select one): ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Pacific Islander ☐ White ☐ Other

Ethnicity: Hispanic or Latino Ethnicity? ☐ YES ☐ NO

Smoking Status (select one): ☐ Current every day smoker ☐ Current some days smoker
☐ Former smoker ☐ Never smoker

Is this medical treatment related to an accident: MVA (Motor Vehicle Accident) _____

Workers' Comp _____ Date of Injury _____

2 Insurance Information

We have your insurance on file, but please provide the subscriber information to your primary & secondary insurance.

Primary Insurance: _____

Subscriber: _____

Date of Birth: _____ Relationship to Patient: _____

Secondary Insurance: _____

Subscriber: _____

Date of Birth: _____ Relationship to Patient: _____

PLEASE TURN OVER

Neurodiagnostics Inc., D/B/A Lexington Diagnostic Center

1725 Harrodsburg Road • Suite 100 • Lexington, Kentucky 40504

LEXINGTON DIAGNOSTIC CENTER & OPEN MRI

I, _____ (patient or parent/legal guardian of patient), give Neurodiagnostics Inc., D/B/A Lexington Diagnostic Center (LDC) permission to bill _____'s (patient) insurance, workers' compensation, motor vehicle insurance and/or attorney for today's services.

I understand that it is my responsibility to make sure that all insurance company requirements are met, such as obtaining a written referral, notification or preauthorization. I understand that if I fail to complete any of these requirements, my insurance company may deny or reduce my benefits. I understand that any denial or reduction of benefits will result in additional payment responsibility from me. *As a courtesy, we contact your insurance company and obtain an estimate of your benefits. I understand I may be billed additional dollars if the quote(s) are inaccurate.*

I understand that LDC will attempt to collect funds for the benefit of me (or the patient) from the insurance company. However, in the event the insurance company (except workers' compensation) delays payment for longer than 45 days, LDC will expect payment from me, even if I have insurance coverage or if any other person or entity will ultimately pay for the patient's services.

I understand that I am ultimately responsible for this bill. I understand in attempting to collect this bill I may be contacted via mail, e-mail, cell phone, or home phone.

If this is a workers' compensation claim and the claim for today's services is denied for any reason, I am financially responsible for today's services.

I irrevocably assign LDC, its successors and assigns, all benefits payable to me (or the patient) from my health insurance, workers' compensation, motor vehicle insurance and/or attorney for today's services. This assignment does not release me from my responsibility to pay LDC as I have agreed.

I hereby certify that the information provided on this form is complete, true and correct to the best of my knowledge.

I acknowledge that I have received a copy of the Lexington Diagnostic Center & Open MRI's Notice of Privacy Practices.

_____ _____

Printed name of patient or patient's representative | Relationship of representative to patient

_____ _____

Sign Here Signature of patient or patient's representative | Date

LDC will provide your referring doctor with the report regarding the results of this test. In most cases, the imaging interpretation and report turnaround time will be between 24 and 48 hours, but could take up to 1 week. We are not an emergency or urgent care imaging center. We are an outpatient imaging facility. If you have a medical emergency, you should go to the emergency room for further evaluation.

Please list any additional physicians or other treating providers that you would like to receive a copy of the report from this test.

Full name of physician or other treating providers.	Address, City, State and Zip Code if known.