TULSA DIAGNOSTIC IMAGING

6046 S SHERIDAN RD
TULSA, OK 74145
PHONE: 918.499.1674
FAX: 918.499.1675

PATIENT FINANCIAL INFORMATION

Thank you for choosing Tulsa Diagnostic Imaging for your MRI. We are committed to providing quality care and service to all of our patients. The following is a statement of our financial policy and assignment of benefits, which we require that you read and agree to prior to any services.

- For personal injury cases, we will bill the insurance claim for you. After doing so, we file a physician's lien against all claims corresponding to this date of loss, yourself, and any legal representation. This protects Tulsa Diagnostic Imaging upon settlement of your claim. You may request a copy at any time.
- If you are represented by an out-of-state attorney or law firm, we require a letter of protection (LOP) to be on file before services are rendered.
- We will attempt to confirm your insurance claim information prior to services. It is your responsibility to provide current and accurate insurance information, including any updates or changes in coverage. Should you fail to provide this information, you will be financially responsible.
- If your insurance company requires additional documentation from you, it is your responsibility to provide them with the requested information. Failure to do so may result in your claim being denied or closed without payment.
- If your injuries a.) are work-related, b.) your accident occurred while you were on the clock, or c.) you were in a work vehicle, and you conceal or fail to disclose that fact, the entire bill amount will become your responsibility and subject to collections efforts.
- Tulsa Diagnostic Imaging charges $1900.00 for each body part scanned, plus any applicable fees.
- We are not in network with any health insurance carriers and will not submit claims to them. Payments made towards your account balance will not be applied to any health insurance deductibles.
- All charges are ultimately your responsibility. In the event your claim is denied, closed without payment, or your account is not paid from settlement proceeds, you will be responsible for the balance.
- **If your balance remains unpaid for more than 90 days, a payment agreement will be put in place. This will allow you to pay towards the amount due until your insurance claim settles.**
- Returned checks are subject to a $50.00 fee.

I authorize Tulsa Diagnostic Imaging to inquire on the status of any personal injury claims for which I am receiving treatment or regarding policy or claim information that may pertain to payment for treatment. I authorize my insurance benefits to be paid directly to Tulsa Diagnostic Imaging, including any first- or third-party liability settlements, MedPay, uninsured or under-insured motorist claim. If my endorsement is required on a payment check, please accept this as authorization to endorse by Tulsa Diagnostic Imaging.

I further understand and agree that if my account is assigned to collections or a collection agency for recovery of the amount owed on the account, Tulsa Diagnostic Imaging shall be entitled to assess a collection fee comprising 25% of the principal balance owed on the account at the time of referral for collection, and Tulsa Diagnostic Imaging and any of its assignees shall further be entitled to recover reasonable attorney fees, collection costs, and agency fees incurred in collection of the account.

I have read the financial policies contained above, and my signature below serves as acknowledgement of a clear understanding of my financial responsibility. I understand that if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in full.

Signature: ______________________________ Date: ______________________

Printed Name: ______________________ Relationship to Patient: ______________________

SAFETY SCREENING & INJURY INFORMATION

Please *CIRCLE YOUR ANSWERS* below to ensure your safety during your MRI:

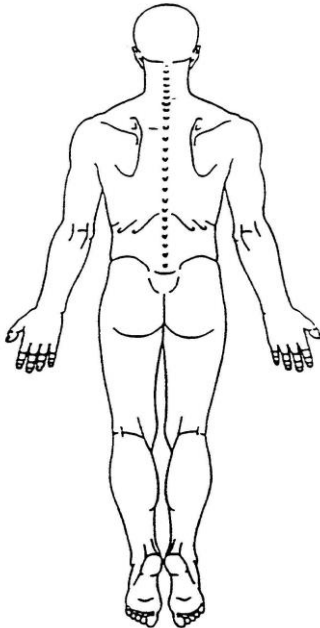
1. Yes No Have you had any previous surgery on the body part we are scanning today?
   If yes, please explain: ______________________________
2. Yes No Have you ever had surgery on any of the following body parts? If so, please circle:
   Eye Ear Heart Head / Brain
3. Yes No Have you ever had an MRI before? If yes, what body part: ______________________
4. Yes No Have you ever been diagnosed with cancer? If yes, what type: ______________________
5. Yes No Have you had any kind of procedure, surgery, endoscopy, or colonoscopy within the last 8 weeks?
   If yes, please explain: ______________________________
6. Yes No Do you have ***ANY*** implanted metal, electronic or medical devices such as:
   - Braces, dentures or dental implants - Brain aneurysm clips or CSF shunt - Bone or nerve stimulators
   - Pacemaker, defibrillator, or stents - Ear implant or hearing aid - Insulin or pain pump

   If yes, please explain: ______________________________
7. Yes No Is there any chance you may be pregnant?
8. Yes No Do you have any type of body piercings, facial tattoos or permanent make-up?
9. Yes No Have you ever worked with metal such as machine shop work, grinding, or filing metal?
10. Yes No Have you ever had metal in your eyes or body? If yes, was it removed by a physician? Yes No
    What kind of metal: ______________________ Where: ______________________

    If not removed by a physician, please read and sign the following:
    I have been informed that a complication could arise from having an MRI done with metal in my eye(s) or body. I understand that this MRI could cause it to move or become hot and it is my responsibility to notify the tech if such occurs. I take sole responsibility for proceeding with my MRI.

    Signature: ______________________________

Please circle areas of pain:



How many vehicles were involved?

How many people were in your car?

Were you a: Driver Passenger Pedestrian Cyclist

Please circle how the accident or injury occurred:

T-boned Rear-ended Head-on Fall Hit by object

Other: ______________________________

Please describe your symptoms today:

What type of vehicle *caused* the accident?

Semi /Bus Car / Pickup / Van / SUV Motorcycle Bike ATV/Off-road

What type of vehicle were *you* in?

Semi /Bus Car / Pickup / Van / SUV Motorcycle Bike ATV/Off-road

I certify that I have answered these questions truthfully and to the best of my ability and I consent to Tulsa Diagnostic Imaging performing MRI(s) for myself or my minor child listed above.

Signature: ______________________ **Date:** ____________ **Relationship to Patient:** ______________

TULSA DIAGNOSTIC IMAGING

6046 S SHERIDAN RD, TULSA, OK 74145
PHONE: 918.499.1674 FAX: 918.499.1675

OKLAHOMA STANDARD AUTHORIZATION
TO USE OR SHARE PROTECTED HEALTH INFORMATION (PHI)

Patient Name:____ **Date of Birth:**__________________________

I hereby authorize Tulsa Diagnostic Imaging to release the following information:

■ Entire medical record, including billing

☐ Images

☐ Medical information compiled between __________________ and _______________________

Persons / Organizations authorized to receive my information and reason (circle one):

Attorney name:____ for legal purposes.

Name:____ Continued Medical Care Other:_________________

Name:____ Continued Medical Care Other:_________________

Name:____ Continued Medical Care Other:_________________

Name:____ Continued Medical Care Other:_________________

I understand that by voluntarily signing this authorization:

- I authorize the use or disclosure of my PHI as described above for the purpose(s) listed.
- I have the right to withdraw permission for the release of my information, and can revoke this authorization at any time. I understand to do so, I must provide revocation in writing to the person / organization disclosing the information and that it will not affect the information that has already been used or disclosed.
- I have the right to receive a copy of this authorization.
- I understand that unless the purpose of this authorization is to determine payment of a claim for benefits, signing this authorization will not affect my eligibility for benefits, treatment, enrollment, or payment of claims.
- My medical information may indicate that I have a communicable and / or non-communicable disease which may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea, HIV, AIDS, and / or may indicate that I have or have been treated for psychological or psychiatric conditions or substance abuse conditions.
- I understand I may change this authorization at any time by writing to the person / organization disclosing my PHI.
- I understand I cannot restrict information that may have already been shared based on this authorization.
- Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no long be protected by the Privacy Regulation.

Unless revoked or otherwise indicated, this authorization's automatic expiration date will be one year from the date signed. ____

____

Signature: ____ Date:__________________________________

Printed Name: ____ Relationship:__________________________________