18501 Pines Blvd Ste 205-B
Pembroke Pines, Fl 33029
Phone: 954-278-9088
Fax: 954-607-5825

Patient Name _____ Date of Birth_____

Sex: M / F Weight _____ Height_____ Age _____

Allergies:_____

List all previous Surgeries_____

Are you Claustrophobic □ Yes □ No

If yes please indicate if you have taken medication for claustrophobia □ Yes □ No

Medical History

YES	NO		NO	YES	
____	____	Stents	____	____	Joint Replacement
____	____	Aneurysm Clips	____	____	Artificial Limps
____	____	Ear Implants	____	____	Brain Surgery
____	____	Cardiac Valve Replacement	____	____	Ear Surgery
____	____	Denture and or Partials	____	____	High Blood Pressure
____	____	Hearing Aids(Please Remove)	____	____	Shrapnel, Bullets, BBs
____	____	Neurostimulator	____	____	History of Cancer
____	____	Cardiac Pacemaker	____	____	Pregnant
____	____	Diabetes	____	____	Have you been a
____	____	Kidney Disease	Machinist, Welder, or Metal Worker		
____	____	Implanted Pain Pumps			
____	____	Insulin Pump			
____	____	Any other removable Pump			

I have answered all of the questions truthfully, and do not hold Logic Diagnostic Inc responsible for any harm to me based on any false information given by me.

_____ _____

Patient Signature Witness Signature

Date:_____

ASSIGNMENT OF BENEFITS

I, _____ (Name of Patient) requests that payment of authorized insurance benefits , including Medicare if I am a Medicare beneficiary to be made on my behalf to Logic Diagnostic Inc. for all services rendered to me by Logic Diagnostic Inc.

I, _____(Name of Patient) authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related services to the organization, Center for Medicaid & Medicare Services , my insurance carrier or other medical entities. A copy of this authorization will be sent to the Center of Medicaid & Medicare Services, my insurance Carrier, or other medical entity if requested. The original authorization will be kept on file with the organization.

I understand that I am financially responsible to Logic Diagnostic Inc for any charges not covered by health care benefits. It is my responsibility to notify Logic Diagnostic Inc of any changes to my health care coverage.In some cases exact insurance benefits cannot be determined until the insurance carrier receives a claim. I am responsible for the for the entire bill r balance f the bill as determined by the organization and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form I am accepting financial responsibility asp explained above for all payment for services received.

By signing this document, I also acknowledge that I have been made aware of my privacy rights per HIPPA Law.

Signature_____ Date_____

Witness _____

18501 Pines Blvd Ste 205-B, Pembroke Pines, Fl 33029

T: (954) 278-9088 F: (954) 607-5825 E: info@logicdinc.com

PATIENT PAYMENT FORM

I _____ will pay the amount of $_____ ☐ In Full ☐ Through Payment Arrangements For my ☐ Copay ☐ Deductible ☐ Service with ☐ Cash ☐ Credit Cards

(Note: We do not accept Check)

FOR PAYMENT ARRANGEMENT

I _____ give Logic Diagnostic the right to withdraw $_____ per month / per week (Circle One) for the next _____ months.

Credit Card Info: Circle One Visa Mastercard Discover American Express

Name on Credit Card:_____

No._____ Exp _____ Security_____

Signature: _____

We will attempt payment one time after a declined transaction at no additional charge and will **charge $20.00 reprocessing fee for each Declined transactions**.