Request for THIRD PARTY PAY NON-OHIP MRI

Phone *416-886-0304* ***Fax*** ***1-888-391-3608***
www.axxessimaging.com

Appointment Information

Date ____________ **Time** ____________

Patient Information

Name ____________
OHIP # ____________ VC ____________
DOB (d/m/y) ____________ Sex ☐M ☐F
Address ____________
City ____________ PC ____________
Phone ____________
EMAIL ____________

Area to be Scanned

____
____
____

Clinical Information

____
____
____

Does Your Patient Have Any of the Following MRI Safety Risks? (<u>Must</u> be Completed - Especially Kidney Questions)	Yes	No
Possibility That You Are Pregnant		
Any Injury Ever to Your Eye(s) From a Metal Object		
Any Injury Ever From a Metal Object (eg., Bullet, Shrapnel)		
Cardiac Pacemaker, Implanted Cardioverter Defibrillator		
Intracranial Aneurysm Clips		
Surgical Staples, Surgical Clips, Metallic Sutures		
Metallic Filter, Stents, Coils, Shunt		
Neuro/Bio-Stimulator, Drug Infusion Pump		
Electronically or Magnetically Activated Device		
Vascular Access Port, Catheter		
Artificial Heart Valve		
Tissue Expander		
Orthopedic Hardware (eg., Joint Replacement)		
Prosthetic Device (eg., Limb, Penile, Eye, Ear)		
Intrauterine Device, Diaphragm, Pessary		
Body Art (eg., Tattoos, Permanent Makeup, Body Piercings)		
Dental Appliance (eg., Dentures, Braces, Retainer, Plates)		
Medication Patch (Specify) ____________		
Claustrophobia (Referring Doctor is Responsible for Sedation)		
Acute Renal Failure		
Chronic Kidney Disease		
On Dialysis		

If Yes, Please Indicate Dialysis Day(s) And Time

☐ **Mo** ☐ **Tu** ☐ **We** ☐ **Th** ☐ **Fr** **Time**: ____________

Supplementary Information

Height ________ cm **Weight** ________ kg
Table Weight Limit is 227 kg/500 lbs

Transportation Requirements
☐ Ambulatory ☐ Wheelchair ☐ Other ________

Creatinine ________ µmol/L
Blood Collection Date (d/m/y) ________

Allergies ________

Previous Imaging (Reports <u>Must</u> be Attached)
☐ MRI ☐ CT Scan ☐ X-Ray
☐ Ultrasound ☐ Angiogram ☐ Nuclear Medicine

Previous Surgeries (Reports <u>Must</u> be Attached)
☐ Head/Neck ________
☐ Spine ________
☐ Heart/Chest ________
☐ Abdomen/Pelvis ________
☐ Extremities ________

Implant/Device Details
Make ________ Model ________
Date Implanted (d/m/y) ________
Make ________ Model ________
Date Implanted (d/m/y) ________

Patient Signature ________

Referring Doctor Information

Name (PRINT) ____________
Address ____________
City ____________ PC ____________
Phone ____________ Fax ____________
Signature ____________
CPSO # ____________ Billing # ____________

Department Use Only

Radiologist Code ____________
Radiologist Signature ____________
MRT Code ____________ ☐ 1.5T ☐ 3T
MRT Signature ____________

INCOMPLETE, ILLEGIBLE AND/OR UNSIGNED REQUISITION FORMS WILL BE RETURNED

THIRD PARTY PAYOR INFORMATION FORM

TEL: 416-886-0304 FAX: 888-391-3608

Company Name: ______________________________________ **Contact Person:** ______________________________________

Address: ____

Phone # ______________________________________**E-Mail** ____

I hereby authorize the MRI/ CT facility to release, by any means including email or fax, information and records related to my medical examination to the referring physician, to Axxess Imaging and/or to the above noted third party payor (the "Payor"), and/or to any other person or entity for any purpose related to the provisions of the Insurance Act, the Workplace Safety and Insurance Act, the Health Insurance Act and/or any Regulation thereto (including the Statutory Accident Benefits Schedule). I also acknowledge that the Payor will be invoiced for the full fees that would be charged for my examination in the event that I do not / did not attend a scheduled appointment. Also, once an appointment is scheduled and confirmed there are NO cancellations or changes.

THIRD PARTY SERVICES: A "third party service" is a service that is provided to a person by a physician, hospital or other service provider in connection with a request or requirement, made by a third party, that the service be provided to the person, or that information relating to the person be provided to the third party. The third party that makes the request or requirement is liable for payment to the service provider for the service provided to the person specified. Third party services that are not insured by OHIP are those which are received wholly or partly for the production of a document, or the transmission of information to the third party, if the document or the information relates to (check the box below that applies):

- ☐ admission to/continued attendance in a school/educational program/recreational/athletic club/program
- ☐ an application for/continuation of insurance or for/continuation of a license
- ☐ obtaining/continuing employment or entering/maintaining a contract or absence from/return to work
- ☐ an entitlement to benefits, including insurance or pension benefits
- ☐ legal requirements/proceedings
- ☐ **OTHER NON-OHIP:** Some health care services are otherwise excluded from services insured by OHIP under provincial regulations (e.g., exam not meeting specific OHIP criteria for particular body part, exam in support of treatment considered experimental, exam for purpose of clinical research, etc.)
- ☐ **NON-RESIDENT:** Only persons who are ordinarily resident in Ontario, as well as certain other persons deemed to be residents under provincial regulations, are entitled to receive OHIP-insured services without charge. Therefore, services provided to non-residents of Ontario are not insured by OHIP.

The patient, referring physician/physician's agent and/or third party/third party's agent (if applicable) hereby certify that the patient meets all of the requirements of the category checked above.

PATIENT SIGNATURE **THIRD PARTY PAYOR SIGNATURE**

____ ____

IN CLINIC PATIENT SIGNATURE: ____

Third Party Payor Waiver Form

Attention:

We have received a referral form to schedule your client/patient,____________________________________, for a Medical Imaging examination.

As you may be aware, Axxess Imaging provides access to diagnostic imaging examination services to third party payers. Individuals cannot pay for a Medical Imaging examination privately.

We have implemented a policy whereby we are requesting that our third party clients provide us with an assurance that they are paying for the Imaging examination of the Ontario resident they are sending to Axxess Imaging. In addition it is understood that the corporation is paying for this service as an entitlement to a corporate health benefit.

As soon as we receive a fax or email of this completed form, we would be happy to assist you in booking the appointment for your client. We appreciate your assistance in this matter.

____

TO BE COMPLETED BY REPRESENTATIVE OF THIRD PARTY PAYER

This will confirm that our client/patient, ____ is not paying for his/her Medical Imaging examination privately. The third party responsible for payment of this corporate benefit is:

____

Name and full address of company : Address Line 1

____

Address Line 2

____ __________________________________

Authorized Signature Name and Title (Please Print)

____

Date

Please send this completed form by fax to at **1-888-391-3608** or scan and email to **laura.miller@axxessimaging.com**

If you require assistance with completion of these form please contact 416-886-0304