FIRST LOOK MRI

Medical Records Request

Requesting Party

Name of Organization	
Mailing address	
Address line 2	
City	
State/Zip Code	
Phone	
Fax/Email	

Patient

Patient Name (last, first)	
Date of birth	
Date of exam	
MRI(s) (i.e. lumbar, knee, etc)	
# of exams? (leave blank if unsure)	

- PLEASE FILL IN THIS SECTION TO CALCULATE PAYMENT -			
Requested items	**# of exams**	**Cost per exam**	**Add these charges**
MRI Report ($10 per exam)		$10 =	
Billing information ($10 per exam)		$10 =	
CD of images ($10 per exam)		$10 =	
Mail Records ($10 total)		$10 =	
Notary Fee ($5 total)		$5 =	
		Total Owed:	

** We do not accept checks. Please include credit card information below.

Name on Credit Card/ zip code	Expiration	Security Code	Zip Code
Credit Card Number	**Authorized Signature**		

Send (1) this completed invoice, (2) patient consent, and (3) credit card information to:

Email: info@firstlookmri.com **Fax: 470-777-2617**

(Include notary forms if applicable)