ADVANCED IMAGING

"Advancing the care you deserve." CONCEPTS

MRI PATIENT FORM

Name: _____Weight: _____Date of Exam: _____

HISTORY OF CANCER? YES / NO_____ REASON FOR EXAM (SYMPTOMS): _____

PLEASE LIST PRIOR X-RAYS, CT SCANS, MRI'S, ULTRASOUNDS AND NUCLEAR MEDICINE TESTS YOU HAVE HAD:

TEST PERFORMED DATE FACILITY

_____

_____

LIST PRIOR SURGERIES: _____

DO YOU HAVE HISTORY OF **KIDNEY DISEASE INCLUDING RENAL FAILURE**, OR ARE YOU ON **DIALYSIS**: _____YES _____ NO

Do any of the following apply? YES / NO

_____Aneurysm clip

_____Metal fragment in head, eye past 6 wks

_____Metal spinal rods

_____Neurostimilator (TENS unit)

_____Penile prosthesis

_____Cardiac pacemaker/Cardiac defibrillator

_____Intravascular coils, filters or stents within past 6 weeks

_____Fractures treated with pins screws, nails in Spine or skin (metal worker)

_____Insulin or Morphine pump Or Bone growth stimulator

_____Retinal tack in eye

_____Cochlear implant

_____Permanent Eye Makeup

_____Hearing aid/dentures

_____Claustrophobia

_____ Pregnancy

List ALL medication allergies:_____

List Sedative medication & dose taken for this exam_____

CONSENTS FOR MRI EXAM & CONTRAST

I certify the above information of this form to be correct to the best of my knowledge. I understand that despite precautions, there is a limited risk of complications with this procedure. These complications could include possible injury if questions are incorrectly answered on the form. I give consent for this MRI scan to be performed.

Patient /Guardian Signature: _____ Date: _____

Your Doctor or the Radiologist has, or may, request the use of Gadolinium. Gadolinium is a MRI contrast agent that is given intravenously and may add useful information to your MRI examination. There is a small but significant possibility of an allergic reaction, which, in rare cases, could be fatal. I grant my permission for use of Gadolinium contrast.

Patient /Guardian Signature: _____ Date: _____

Technologist Signature: _____ Date: _____

Address: 13470 Taft Street Brooksville, FL 34613 *Phone: 352-597-0016* *Fax: 352-597-0089*

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LIFETIME AUTHORIZATION

INSURANCE ASSIGNMENTS AND AUTHORIZATION TO RELEASE INFORMATION

I. **RELEASE OF INFORMATION**: I below named patient, do hereby authorize any physician examining and/or treating me to release any third payor (such as an insurance company or government agency, example: Blue Shield of Florida or Medicare) any medical records concerning diagnosis and treatment when requested by such third party for its use in connection with determining a claim for payment.

II. **PHYSICIAN INSURANCE ASSIGNMENT**: I, the below named patient or legal representative of patient , hereby authorize payment directly to Advanced Imaging Concepts, P.L. or any physician treating me in the group and/or medical benefits herein specified and otherwise payable to me for their services as described but not to exceed the reasonable and customary charges for these services.

III. **MEDICARE/MEDICAID**: Patient's certification authorization to release information and payment requests. I certify that the information given by me is applying for payment under Title XVIII/XIX of the Social Security Administration/Division of Family Services or its Intermediaries or carries any information needed for this of a related Medicare/Medicaid (CMS) claim. I hereby certify all insurances pertaining to treatment shall be assigned to the physician treating me.

IV. **I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE WHICH IS NOT A PROVIDER CONTRACTABLE WRITE OFF**. I understand that Advanced Imaging Concepts (AIC) will make every effort to verify my insurance benefits and determine patient responsible amount prior to services rendered. This is not a guarantee of payment or benefits which will not be fully decided until the insurance plan processes the claim. In the event that there is a difference in the amount collected from the patient from what is patient responsibility determined by your insurance plan then the patient may be billed or refunded the difference.

V. **Under our Courtesy Billing Program,** we have asked your insurance company to pay us directly; however, some insurance companies may pay the patient instead. If this occurs, you are responsible to remit this amount to Advanced Imaging Concepts. We recommend that you submit a copy of the explanation of payment that comes with the check so we can determine any discounts that are to be made on the charges.

VI. **NOTIFY US IMMEDIATELY OF ANY CHANGES IN YOUR INSURANCE OR CHANGES IN YOUR ADDRESS AND TELEPHONE NUMBER**: Failure to notify us of changes or failure to notify us of all insurance coverages that are in effect could result in unnecessary patient responsibility of charges. It is extremely important to notify us if the services you are having are related to an accident or injury. We will need the date of this injury and the insurance that may be responsible for coverage. Failure to do so could result in denial of payment from your medical insurance carrier.

PATIENT SIGNATURE_____ DATE: _____

PRINTED PATIENT NAME: _____

LEGAL GUARDIAN OR RESPONSIBLE PARTY SIGNATURE (IF APPLICABLE)

SIGNATURE: _____ DATE: _____

RELATIONSHIP TO PATIENT: _____

PLEASE SEE OTHER SIDE >>>

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Dear Patient:

Advanced Imaging Concepts may use your protected health information for purposes of providing treatment, obtaining payment for treatment and conducting healthcare operations. You may receive a copy of our Notice of Privacy Practices for Protected Health Information, upon request as described in the Health Insurance Portability and Accountability Act of 1996, commonly known as HIPAA. This policy safeguards your personal health information. To comply with this law and to protect you we want you to know how we handle specific situations; so, we have summarized our policy below on some key situations:

PATIENT CONTACT:

1. We may send you a reminder letter through the mail when you are due for a routine appointment, such as but not limited to, a yearly reminder to schedule a mammogram.
2. We may call your home to remind you of a scheduled appointment. If you are unavailable or we reach your answering machine we may leave a message stating your name, and that you are scheduled for an appointment on a specific day, date and time. We may also leave instructions for a test preparation and any co payment that may be due at the time of the service. We will not state the name of the test that you are scheduled for.

If you *do not* want us to contact you in this manner please state what your wishes are we will do everything we can to honor them:

_____

_____

_____

_____

_____

MEDICAL RECORDS RELEASE:

1. **It is our policy to release medical records such as films and reports to any healthcare provider or family member, if requested, with proof of identification such as drivers license. I authorize the release of my medical records and/or x-ray film to AIC or from any healthcare entity as necessary for continued healthcare and comparison.** If there is a specific healthcare provider or family member you do not want us to release medical records to or you want us to handle your release in a specific way other then our normal policy than please tell us below:

   _____

   _____

   _____

Please sign this form, which will be added as part of your medical record confirming that you are aware of our Notice of Privacy Practices and that you have read this acknowledgment form and agree with our policy or have made changes in the spaces provided.

PATIENT'S SIGNATURE: _____**DATE**: _____

PRINTED NAME: _____

PLEASE SEE OTHER SIDE >>>

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