ADVANCED IMAGING CONCEPTS, PL.

Date: _____ **MRI PATIENT FORM**

Name _____ Age _____ Weight _____

Date of Birth _____/_____/_____ Male / Female

1.Reason for MRI and/or Symptoms:_____

2.History of Cancer: No /yes

If yes, please describe: _____

3. Have you had prior surgery or an operation (e.g., arthroscopy, endoscopy, etc.) of any kind?
No / Yes
If yes, please indicate the date and type of surgery:

Type of surgery _____

_____

4. Have you experienced any problem related to a previous MRI examination or MR procedure?
No / Yes

If yes, please describe: _____

5. Have you ever been injured by a metallic object or foreign body (e.g., BB, bullet, shrapnel, etc.)?
No / Yes

If yes, please describe: _____

6. Are you allergic to any medication? No / Yes

If yes, please list: _____

7. Do you have a history of asthma, allergic reaction, respiratory disease, or reaction to a contrast medium or dye used for an MRI, CT, or X-ray examination? No / Yes

If yes, please describe: _____

8. Do you have anemia or any disease(s) that affects your blood, a history of renal (kidney) disease, or seizures? No / Yes

If yes, please describe: _____

9. **For female patients:** Are you Pregnant or Breast Feeding No / Yes

FOR OFFICE USE ONLY:

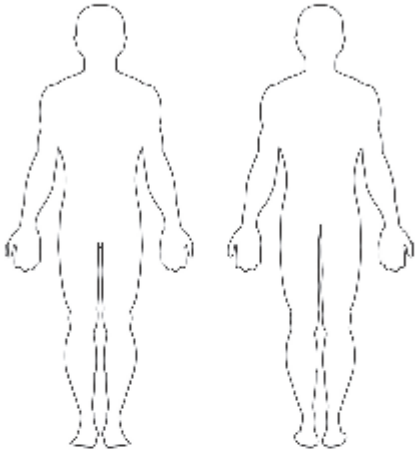
Contrast Used: _____ Injection Site: _____ Adverse Reaction: No/ Yes

WARNING: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure (i.e., MRI, MR angiography, functional MRI, MR spectroscopy). **Do not enter the MR system room or MR environment if you have any question or concern regarding an implant, device, or object. Consult the MRI Technologist or Radiologist BEFORE entering the MR system room. The MR system magnet is ALWAYS on.**

Please indicate if you have any of the following:

- ❑ Yes ❑ No Aneurysm clip(s)
- ❑ Yes ❑ No Cardiac pacemaker
- ❑ Yes ❑ No Implanted cardioverter defibrillator (ICD)
- ❑ Yes ❑ No Electronic implant or device
- ❑ Yes ❑ No Magnetically-activated implant or device
- ❑ Yes ❑ No Neurostimulation system
- ❑ Yes ❑ No Spinal cord stimulator
- ❑ Yes ❑ No Internal electrodes or wires
- ❑ Yes ❑ No Bone growth/bone fusion stimulator
- ❑ Yes ❑ No Cochlear, otologic, or other ear implant
- ❑ Yes ❑ No Insulin or other infusion pump
- ❑ Yes ❑ No Implanted drug infusion device
- ❑ Yes ❑ No Any type of prosthesis (eye, penile, etc.)
- ❑ Yes ❑ No Heart valve prosthesis
- ❑ Yes ❑ No Eyelid spring or wire
- ❑ Yes ❑ No Artificial or prosthetic limb
- ❑ Yes ❑ No Metallic stent, filter, or coil
- ❑ Yes ❑ No Shunt (spinal or intraventricular)
- ❑ Yes ❑ No Vascular access port and/or catheter
- ❑ Yes ❑ No Radiation seeds or implants
- ❑ Yes ❑ No Swan-Ganz or thermodilution catheter
- ❑ Yes ❑ No Medication patch (Nicotine, Nitroglycerine)
- ❑ Yes ❑ No Any metallic fragment or foreign body
- ❑ Yes ❑ No Wire mesh implant
- ❑ Yes ❑ No Tissue expander (e.g., breast)
- ❑ Yes ❑ No Surgical staples, clips, or metallic sutures
- ❑ Yes ❑ No Joint replacement (hip, knee, etc.)
- ❑ Yes ❑ No Bone/joint pin, screw, nail, wire, plate, etc.
- ❑ Yes ❑ No IUD, diaphragm, or pessary
- ❑ Yes ❑ No Dentures or partial plates
- ❑ Yes ❑ No Tattoo or permanent makeup
- ❑ Yes ❑ No Body piercing jewelry
- ❑ Yes ❑ No Hearing aid
  (Remove before entering MR system room)
- ❑ Yes ❑ No Other implant _____
- ❑ Yes ❑ No Breathing problem or motion disorder
- ❑ Yes ❑ No Claustrophobia

Please mark on the figure below the location of any implant or metal inside of or on your body.



IMPORTANT INSTRUCTIONS

Before entering the MR system room, you will be asked to change into a gown. Please understand that this is a safety requirement and not optional. You must remove all metallic objects including hearing aids, dentures, partial plates, keys, beeper, cell phone, eyeglasses, hair pins, barrettes, jewelry, body piercing jewelry, and watch.

NOTE: You may be advised or required to wear earplugs or other hearing protection during the MR procedure to prevent possible problems or hazards related to acoustic noise.

Please consult the MRI Technologist if you have questions or concerns before you enter the MR Suite.

I have read and understood and hereby consent to this MRI examination. I understand the use of contrast material may be recommended by my doctor for this exam.

Patient Signature_____Date:_____

I have reviewed and discussed these safety items with the above signed patient or guardian and approve this patient for magnetic resonance imaging.

Technologist Signature: _____ Date: _____

ADVANCED IMAGING CONCEPTS, PL

Authorization and Assignment

I request that payment of Authorized Medicare/Insurance Benefits be made either to me on my behalf for any services furnished by **ADVANCED IMAGING CONCEPTS PL**. I authorize any holder of medical information about me to release to CMS/Insurance carriers and its agents any information needed to determine these benefits related to services.

I herby authorize **ADVANCED IMAGING CONCEPTS PL** to furnish information to CMS/Insurance carriers concerning my medical condition, illness, and treatment to determine the benefits for related services. I herby authorize (assign) my insurance carrier(s)/CMS to make payment directly to **ADVANCED IMAGING CONCEPTS PL** for medical/diagnostic/surgical benefits payable for the services rendered. I understand that any unpaid balance(s) not covered by this policy will be my responsibility. I understand and agree (regardless of my insurance status), that I am ultimately responsible for the balance of any professional services rendered. I understand that I am responsible for any charges incurred if my account is sent to collection agency and for any returned checks. I understand that CMS/and or other insurance carriers do not cover all office services/procedures. **I agree to take full responsibility for any unpaid balances and that such payment will be made to the office for services rendered.** I certify that the information I have given here is true and correct to the best of my knowledge. I will also notify **ADVANCED IMAGING CONCEPTS PL** of any changes in the above information.

X Signature: _____ **Date:** _____

Designated Relative:

I authorize discussion and release of my general medical condition and diagnosis (including treatment, payment, and healthcare operation) with the following. In case of an emergency, we will contact the designated relative(s) or significant other listed below.

Name:_____ Relationship: _____ Phone: _____

Name: _____Relationship: _____ Phone: _____

Name: _____Relationship: _____Phone: _____

Messages may be left on my answering machine regarding my health and appointment made: YES ___ NO____

EMAIL ADDRESS: _____

HIPAA PRIVACY NOTICE:

I have received a copy of **ADVANCED IMAGING CONCEPTS PL** Privacy notice.

X Signature: _____ **Date:** _____

Patient Name: _____

X LEGAL GUARDIAN SIGNATURE: _____**Date:** _____

Legal Guardians Name: _____

Patient Privacy Rights:

You have the right to:

- Inspect and copy medical information from your chart. You may submit a written request to our office and receive a copy of your record. We must respond within 30 days if the record is readily available and within 60 days if it not readily available. You may also get an electronic copy if we have one available.
- Amend medical information in your chart. You may identify inaccurate or incomplete information in your chart. You can do this with a written request to amend your chart directed to our office. We must respond within 60 days.
- Receive an accounting of any disclosures made from your record over the last 7 years. You can get this with a written request directed to our office. We must respond within 60 days.
- Request restriction as the amount of medical information we disclose. This is limited as noted above, and your request my not supersede the typical disclosure noted above. You may revoke or restrict the consent. We cannot disclose self-pay services if you object.
- Request confidential communications. All communications in our office are confidential with a written request to our office.
- Not have your protected health information sold for marketing purposes.
- Opt out of receiving fundraising communications.
- Receive a copy of this notice by printing it or with a written request directed to this office.

We may contact you for the appointment reminders, and we may provide you with information about health related or product benefit services. Each patient is given a copy of the Privacy Notice and an opportunity to review and understand it.

Our Responsibilities under HIPAA:

We are required by law to maintain the privacy of your personal health information, and to provide you notice of our legal duties and privacy practices and adhere to this notice. We reserve the right to make changes to this notice. We will post a notice that the notice has changed and the effective date of the change, copies will be made available.

You can submit a complaint about our privacy policy or its execution either verbally or in writing to our **Privacy Officer** at our office.

If you get no resolution to your complaint, you can send a written statement to this office or the Secretary of Health and Human Services.

Permission For Treatment

I, the undersigned, hereby voluntarily consent to Medical Care/diagnostic treatment and or minor surgical treatment by **ADVANCED IMAGING CONCEPTS PL,** deemed advisable and necessary in the diagnosis and treatment of my condition. I am aware that the practice of medicine is not exact science and I acknowledge that no guarantees have been made to me as result of treatment or examination in the office. I authorize the release of any of my past/current medical records that are needed for treatment from any prior healthcare providers.

X Signature: _____ Date: _____