Patient Name: ____

DOB: _____________________________ **DATE:**__________________________

Current Smoker ❑Yes ❑No

Former Smoker ❑Yes ❑No

Do you use tobacco? ❑Yes ❑No

Are you currently taking any medications? ❑Yes ❑No
If yes, please list the medications:

_______________________________________ _____________________________________

_______________________________________ _____________________________________

_______________________________________ _____________________________________

_______________________________________ _____________________________________

_______________________________________ _____________________________________

_______________________________________ _____________________________________

Please list any medications that you are allergic to:

_______________________________________ _____________________________________

_______________________________________ _____________________________________

_______________________________________ _____________________________________

Patient Demographics

Name:____ DOB:__________________ SS#:____________________________

Address:____
PO Box or Street Address City State Zip Code

Phone Numbers: Home:_________________________________ Cell:___________________________________

Email Address:____

How would you like for us to contact you? ❑Phone ❑Email

Gender: ❑Male ❑Female Marital Status: ❑Single ❑Married ❑Divorced ❑Widowed ❑Separated

Primary Language:
❑English ❑Spanish ❑Other:______________________________________

Race: (please check all that apply)
❑White ❑Black or African American ❑Asian
❑American Indian or Alaska Native ❑Native Hawaiian or Other Pacific Islander

Ethnicity:
❑Hispanic or Latino ❑Not Hispanic or Latino

Employer Information

Company Name:____ Work#:_________________________________

Address:____
Street Address City State Zip Code

Insurance Information

Primary Insurance

Insured Name:_______________________________________

DOB: ____

Secondary Insurance

Insured Name:____

DOB: ____

Please list any person(s) that may have permission to have access to your information (i.e. pick up films/disk/report) or be used as an emergency contact

Name:____

Relationship:_____________________________________

Phone Number:___________________________________

Name:____

Relationship:____

Phone Number:_______________________________________

Is your visit today related to an injury or accident? ❑Yes ❑No
(If yes please complete section below)

Injury due to: ❑Work ❑Auto ❑Trauma ❑Slip/Fall
Date of Injury:_______________________ Time of Injury:_________
Location of Injury: examples (home, skiing, walking, etc.)____
What part of your body was injured?(be specific)____
Have you been receiving treatment for this injury? ❑Yes ❑No
If yes, who is the doctor treating you for the injury?____

Patient Signature X:____ Date:___________________________

MRI/MRA - BRAIN EXAM

Name________________________________ Date ____________________

Age_________ Weight __________

Please give a brief description of your symptoms related to the area to be scanned:

____

____

Was the onset of your symptoms related to an injury? Yes___ No___

Are you having headaches? Yes___ No___

If yes, give location, duration, and length of time you have had headache.

____

____

Have you had any surgeries or any confirmed abnormalities of the brain?

____

____

Do you have any of the following symptoms?

	Yes	No	Description
Loss of Balance	___	___	_________________________
Hearing loss	___	___	_________________________
Tinnitus (ringing in ears)	___	___	_________________________
Dizziness (vertigo)	___	___	_________________________
Weakness	___	___	_________________________
History of Stroke	___	___	_________________________
Vision problems	___	___	_________________________
History of cancer or tumor	___	___	_________________________
Loss of function of legs or arms	___	___	_________________________
Tingling or Numbness in legs/arms/face	___	___	_________________________
Memory loss	___	___	_________________________
Pituitary gland tumor	___	___	_________________________
Slurred speech	___	___	_________________________
Difficulty forming words	___	___	_________________________
Any other symptoms	___	___	_________________________

Prior scans:

CT	Yes ___	No ___	When _________	Where ___________________
MRI	Yes ___	No ___	When _________	Where ___________________
X-ray	Yes ___	No ___	When _________	Where ___________________
Nuc medicine	Yes ___	No ___	When _________	Where ___________________

Technologist Only

Contrast Yes_____ No ____ If yes Amount ___________

Lab values (If needed) GFR ______ Creatine ______ Fluoro Time ______

Referring Physician DX ____

Tech Initials ___________

Open Upright MRI

Patient Name:____**DOB:**__________________ **DOS:**__________________

PLEASE READ AND INITIAL THE FOLLOWING:

_______ **CONSENT FOR MEDICAL TREATMENT:** I authorize the above referenced center to furnish the necessary medical procedure that has been ordered by my physician. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of diagnostic procedures in the above referenced center. I recognize that the physicians who practice at the Center are not employees of the above referenced center, but are independent physicians. The above referenced center may delegate to these independent physicians those services physicians normally provide. Any questions related to my care should be directed to my physician.

_______ **ASSIGNMENT OF BENEFITS:** I hereby authorize payment directly to the above referenced center of any and all medical benefits applicable and otherwise payable to me. I understand that I am financially responsible to the Center for charges not covered by this assignment. I also understand that the Center is filing my claim as a courtesy to me and that unless stipulated in a contract with my carrier, I am responsible for payment of this claim.

_______ **AUTHORIZATION FOR RELEASE OF INFORMATION:** I hereby authorize the above referenced center to release any information requested by the insurance company necessary to collect benefits on this claim. Unless noted below, this authorization includes, but is not limited to, the release of information related to drug, alcohol, HIV antibody and/or psychiatric testing. I further authorize any physician or institution that attended this patient previously to furnish medical records or information that may be requested by the above referenced center.

_______ **MEDICARE B SIGNATURE AUTHORIZATION:** I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers, or to the billing agent of the Center, any information needed for this claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical benefits to be made to the holder of this assignment on my behalf. I understand that I am responsible for any health deductibles and co-insurance.

_______ **WORKER'S COMPENSATION:** I authorize the above referenced center to furnish written reports of my procedure to any representative, attorney for, or investigator from my Worker's Compensation carrier concerning injuries sustained as a result of accident occurring on _______/_______/_______.

_______ **IF PATIENT IS A MINOR:** I hereby give permission for __________________________________ to be treated at the above referenced center.

_______ **HIPAA NOTICE OF PRIVACY**: I have read the notice of privacy practice of the above referenced center.

_______ **PERSONAL BELONGINGS:** I am personally responsible for my belongings and/or valuables that I have with me in the locker/dressing room or exam room. I will personally make sure I have everything with me before I leave the premises.

_______ **TRICARE/CHAMPUS PATIENTS:** I understand that Tricare is secondary to other insurance plans except for Medicaid and Tricare supplement plans. I agree to provide the above referenced center with all insurance plans that I am currently enrolled so that benefits can be coordinated and the appropriate authorizations can be obtained. I understand that failure to provide correct and accurate information may result in the patient in being responsible for entire balance.

NOTE: I understand that different Payers/Health Plans have different requirements for payment including, but not limited to pre-certification, authorizations, or notifications, timely filing of claims, or that the services be medically necessary as defined by the health plan. I understand that verification of benefits from Patient's Insurance Company is not a guarantee that services are covered or will be paid by the Insurance Company. I also understand that it is MY obligation to know the requirements of my health plan and ensure that they have been fulfilled.

If you did not provide your insurance information today, or if it is not accurate, then you may be obligated to make full payment of all charges. It will be your responsibility to file the claim with your insurance provider. If you provided us insurance information today, you are obligated to pay all co-payments, deductibles, and any non-covered out-of-network/reduced benefits at the time the services are rendered. You have an affirmative duty to make sure that payment and/or correct information for payment is given to the above referenced center for reimbursement of services provided. Be advised there will be a fee of $45 for any returned check.

X____ __________________

Patient/Guardian Signature **Date**

PATIENT CONTACT INFORMATION SHEET

Patient Name: ___________________________________

Social Security Number: ___________________________

Date of Birth: ____________________________________

Any physician, staff, employee or representative of ***Open Upright MRI*** has my permission to discuss my account and medical conditions which may include symptoms, treatments, diagnosis, test results, medication, billing or any other type of protected health information with the following person in order to facilitate and coordinate my care, treatment and payment:

Name:_____________________________ Relationship__________________ Phone#:_______________________

Name:_____________________________ Relationship__________________ Phone#:_______________________

Name:_____________________________ Relationship__________________ Phone#:_______________________

Name:_____________________________ Relationship__________________ Phone#:_______________________

I understand that authorizing the release of my information to the above individual(s) is voluntary and does not affect my access to treatment. I can refuse to sign this form. I can revoke it by writing to ***Open Upright MRI*** or completing a new format at any time. This authorization will remain in effect until I change or revoke it. I understand that if information is shared with the above individual(s) it may be subject to re-disclosure by the individual(s).

Patient Signature:_____________________________________ Date:____

PATIENT DISCLOSURE AND INFORMED CONSENT - MRI

Patient Name____ Weight_____________ Age ______

Because of the presence of a magnetic field the following items should not be taken into the MRI room: Watches, coins, keys, knives, dentures, hair pins, pens, hearing aid, wallet, jewelry, belt, phones, beepers or any other loose metal objects.

PLEASE READ AND CIRCLE YES OR NO TO THE FOLLOWING QUESTIONS:

Question			Question		
Do you have a pacemaker/defibrillator?	Yes	No	Have you had any surgeries? If yes, when & what?	Yes	No
Do you have aneurysm clips?	Yes	No	____________________________________		
Do you have stents, coils or filters in your blood vessels?	Yes	No	Do you have a history of cancer? If YES, what kind? ____________________	Yes	No
Have you ever had surgery on area being scanned?	Yes	No	Do you have any allergies? If YES, what kind? ____________________	Yes	No
Do you have ear or eye implants?	Yes	No	Date of last menstrual period ______/______/______		
Are you wearing any medicated skin patches?	Yes	No	Is there any possibility you are pregnant?	Yes	No
Are you wearing a hearing aid?	Yes	No	Do you have a war injury or gunshot wound?	Yes	No
Are you wearing a wig or hairpiece?	Yes	No	Do you have any metal in your body?	Yes	No
Are you wearing metallic dental appliances?	Yes	No	Do you have any implanted devices such as electrodes, Neurostimulators, heart valves, orthopedic implants,		
Do you have a history of:					
Heart disease?	Yes	No	shunts, infusion pump, or prosthetic appliances?	Yes	No
Kidney disease?	Yes	No	Are you wearing an insulin pump?	Yes	No
Kidney failure?	Yes	No	Do you have any concealed body piercing?	Yes	No
Diabetes?	Yes	No	Do you have an IUD?	Yes	No
High blood pressure?	Yes	No	Do you have on magnetic nail polish?	Yes	No
Are you on dialysis?	Yes	No	Have you ever had radiation therapy or chemo?	Yes	No
Are you over 60?	Yes	No	Have you ever had a contrast injection with any adverse effect?	Yes	No
Any other medical problems? If yes, describe:			____________________________________		
________________________________			Are you currently on any blood thinners?	Yes	No

- **How did you hear about us? ___TV ___Physician ___ Internet ___Friend ___Other _______**
- **Do you have a follow up appointment scheduled? ___No ___Yes If so, when? ________________________________**

CONTRAINDICATIONS:

Since MRI uses an electromagnetic field, **you cannot undergo this procedure if you have any of the following**:

Cardiac pacemaker; cochlear implant; neurostimulators; metal fragments in the eye; implanted drug infusion pump (Medtronics OK); or aneurysm clip implanted in the brain.

Please inform us if you have any other implants not mentioned

PREGNANCY:

The FDA has not established any criteria under which a pregnant woman may be scanned. Therefore, it is the policy of this facility that MR Imaging not be routinely performed on women with known or suspected pregnancy.

CONTRAST:

Your Doctor may have requested that your exam be performed with intravenous contrast media if necessary during the MRI exam. Contrast injection is FDA approved and indicated for use with MRI examinations. Although contrast is very safe and allergic reactions are extremely rare, the possibility of an allergic reaction does exist. In addition, related complications such as pain or swelling at the sight of injection or phlebitis, although rare, are possible. The purpose, benefits and complications of the contrast procedure will be explained to your satisfaction before any injection takes place. A basic kidney function test will be performed if you have a history of kidney disease or kidney failure.

I confirm that the information I provided is complete and accurate to the best of my knowledge.
I have read, understand, and hereby consent to this MRI examination.

____ ______________________________

Patient Signature or Guardian if Patient is a Minor   Date