ADVANCED MRI AND IMAGING

2821 US HWY 27 North • Sebring, FL 33870
Phone: (863) 385-8000 • Fax: (863) 385-8002

Diagnostic Study Registration Form(MRI)

Patient Name ____ Date____________________

Date of Birth _______________ Age ______ Weight ________ Height________ Sex: ___Male _______Female

HOME ADDRESS ____

MAILING ADDRESS ____

PRIMARY CARE PHYSICIAN ____

Patient Home Ph _____________________ Patient Cell Phone _________________ Email_______________________

Have you had any previous X-Rays, MRIs, CTs, DEXA or Ultrasounds? _________ Yes _______No

If yes: What _____________________When __________________Where__________________________

Have you ever smoked? If yes for how long?_________ How many packs a day?___________ If you are an ex-smoker, how long ago did you quit? _____________

Cancer _____Yes _____No

If yes: What type _____________________Body Part _________________________

Radiation therapy: _____Yes _____No Chemotherapy: _____Yes___ No____

Are you **pregnant**? _____Yes ______No

Date of last menstrual period:______________________

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ATTENTION MR PATIENTS AND ACCOMPANYING FAMILY MEMBERS

The MR room contains a very strong magnet. Before you are allowed to enter, we must know if you have any metal in your body.

MRI cannot be performed if Yes is answered to the following 7 Questions. Please read completely and check those that apply.

PACEMAKER, **defibrillator** ,wires , epicardial leads	Yes / No
Brain/aneurysm clip ,coils,inner ear surgery	Yes / No
Tissue expander for future implants e.g Breast.	Yes / No
Retained Small Bowel Endoscopy Capsule	Yes / No
Triggerfish contact lens	Yes / No
Linx reflux management devise for GERD	Yes / No
Penileprosthesis(Duraphase and Omniphase are CI)	Yes / No

Please Indicate If You Have Any Of The Following Items In Your Body:

Ear implant or **HEARING AID** (must be removed prior to MRI)	Yes / No
Infusion pump, or medication pump of any kind	Yes / No
Do you have claustrophobia (fear of enclosed spaces)?	Yes / No
Eye implant or eyelid implant	Yes / No
Electrical stimulator for nerves or bone, spinal cord	Yes / No
Magnetic implant (anywhere in the body)	Yes / No
Skin patch for medication	Yes / No
Coil, filter, Stent or wire in a blood vessel	Yes / No
Artificial limb or joint	Yes / No
Eyelid tattoo , body piercings	Yes / No
Implanted catheter or tube, Glucose Monitor	Yes / No
Artificial heart valve, cardiac stents	Yes / No
Shunt spinal or intraventricular shunt	Yes / No
False teeth, retainers, or magnetic braces, dentures	Yes / No
Surgical clips, staples, wires, mesh, or sutures	Yes / No
Recent surgery (in the last **6-8 weeks**)	Yes / No
Intrauterine device (IUD)	Yes / No
Orthopaedic hardware (plates, screws, pins, rods, wires)	Yes / No
Bullets, BBs or pellets	Yes / No
Metal shrapnel or fragments	Yes / No
Have you ever been a machinist, welder or metal worker?	Yes / No
Have you ever been hit in the face or eye with a piece of metal (including shavings, slivers, bullets or BBs)?	Yes / No
Have you ever had a piece of metal removed from your eye?	Yes / No

The normal function of the MR unit generates electrical currents which may create a sensation of warmth, either in the sides of the imaging unit or in the surrounding coil. If you experience any focal warmth that leads to discomfort, please notify the technologist immediately.

I attest that the answers I have provided to questions on this form are correct to the best of my knowledge. I have read and understand the entire contents of this form and have had the opportunity to ask questions regarding the information on this form. I understand that it is my responsibility to inform the office of any metal and/ or any devices that may be in my body, be failing to do so may cause serious bodily injury or be life-threatening. I agree that should I have any metal in my body and after consultation with a physician, elected to proceed with the MRI, I agree to release advanced MRI and Imaging from any and All liability for any injury,

Patient or Legal Representative Signature: ________________________ Date:__________

AUTHORIZATION/CONSENT FOR DIAGNOSTIC PROCEDURES AND MEDICAL TREATMENT

I, the undersigned patient, or parent , or legal guardian, knowing that I am (or the patient is) suffering from a condition requiring medical care, do hereby consent to such medical care, encompassing routine diagnostic procedures and medical treatment by Advanced MRI and Imaging . I acknowledge that no guarantees have been made to me as to the results of treatment or examination.

Initial

CONSENT FOR THE USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give consent to this practice and all health care providers furnishing care within the practice to use and disclose my protected health information for the purposes of treatment, payment and health care operations.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

Please be advised that our Notice of Privacy Practices provides more detailed Information about how we may use and disclose your protected health information. You have the right to review our Notice of Privacy Practices before you sign this consent.

We reserve the right to change the terms of our Notice of Privacy Practices. You may obtain a copy of the current notice by contacting our Privacy Officer.

You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required to grant your request, but if we do, the restriction will be binding on us.

You may revoke this consent at any time. Your revocation must be in writing, signed by you or on your behalf, and delivered to the above address. You may deliver your revocation by any means you choose but it will be effective only when we actually receive the revocation. Your revocation will not be effective to the extent that we or others have acted in reliance upon this consent.

Initial

ACKNOWLEGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received and had an opportunity to ask questions concerning the above named practice's Notice of privacy practices

Initial

FINANCIAL POLICY

I have received, read and understand the financial policy of Advanced MRI and Imaging. I understand that as my medical care provider, Advanced MRI and Imaging relationship and concern is with me and my health, not my insurance company. All charges are my responsibility. On any balance on my account after 90 days, including those that insurance has not paid, collection action may be taken. If it becomes necessary to collect any sum due, through an attorney, then I the patient agree to pay all reasonable costs of the collection, including attorney's fees, whether suit is filed or not.

Initial

Assignment of Benefits

I authorize direct remittance of payment of all insurance benefits, including Medicare, if I am a Medicare beneficiary, to this provider for all covered medical services and supplies provided to me. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

Sign(Patient or legal guardian):______________________________

Date:________________

Print Name of Patient:________________________________Date of Birth:________

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize the physician/staff of Advanced MRI and Imaging to send artificial, prerecorded, or automated calls and text messages and to release/leave medical information, with the following (please check applicable):

__________ Spouse

__________ Significant other

__________ Family Member (name: ____________________)

__________ Caregiver

__________ Answering Machine

__________ Send artificial, prerecorded, or automated calls and test messages.

I understand and acknowledge that should I need to change how I receive my medical information or messages that it will be necessary to notify my provider/office to those changes.

____

Signature of Patient (of parent/guardian or minor) Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

FOR OFFICE USE ONLY

Print Name: ____

Signature: ______________________________ Date: ________________