Open Multi-Positional MRI SCREENING SHEET

Date:__________________

Patient Name:__________________________________ Phone:___________________ DOB:_____________Weight:_____________

Referring Physician:____

Is this your first MRI? Yes <u>No</u> *If NO, what is the date and locatin of your prior MRI?______________________________

Are you using a walker, wheelchair or cane? <u>Yes</u> No

*If **<u>YES</u>**, Can you bear your own weight briefly without assistance* **Yes No**

PLEASE MAKTO ANSWER ALL QUESTIONS BELOW

Do you have any of the following?

Pacemaker	☐ Yes	☐ No
Implanted Cardiac Defibrillator	☐ Yes	☐ No
Imbedded bullets,BBPellets,Shrapnel	☐ Yes	☐ No
Brain Surgery	☐ Yes	☐ No
Aneurysm Clips/Coils in Brain	☐ Yes	☐ No
Electrical/Nerve/Spine Stimulators	☐ Yes	☐ No
Infusion Pumps	☐ Yes	☐ No
Body Piercing/Bobby pins or hair clips	☐ Yes	☐ No
Prosthetic Limbs (not including replacements)	☐ Yes	☐ No
Tattoo or tattooed eye liner/brow	☐ Yes	☐ No
Transdermal Patch (NicoDerm patch)	☐ Yes	☐ No
Hearing Aid	☐ Yes	☐ No
Dentures or Partials	☐ Yes	☐ No
History of cancer or tumors	☐ Yes	☐ No

Contrast Screening

Please select all that apply:

Renal (KIDNEY) disease	☐ Yes	☐ No
Age 60 or older	☐ Yes	☐ No
Hypertension (High blood pressure)	☐ Yes	☐ No
History of diabetes	☐ Yes	☐ No
Severe liver disease, liver transplant	☐ Yes	☐ No
Any allergies__________________	☐ Yes	☐ No

<u>** Please note that if an exam is ordered with contrast, all LABS need to be drawn within 24 hrs before exam</u>

Arthrogram Screening

Are you allergic to IODINE?	☐ Yes	☐ No

Females

Are you or could you be pregnant?	☐ Yes	☐ No
Are you nursing?:	☐ Yes	☐ No

Have you had radiation and/or chemo therapy ☐ Yes ☐ No *<u>If YES please circle the appropriate choice</u>

Do you require the use of oxygen? *If yes, you will need to bring 50 feet of soft tubing with connector* ☐ Yes ☐ No

IMPLANTS AND SURGICAL HISTORY

Do you have anything implanted in your body that you were not born with? ☐ Yes ☐ No

If yes, WHAT?____and WHERE?____

Have you ever been struck in the eyes with metal shavings? *<u>If yes, you may require an orbital x-ray</u> ☐ Yes ☐ No

Have you had any surgery on the following:

Ears	☐ Yes	☐ No	*If yes, what type?:*____________________________
Eyes	☐ Yes	☐ No	*If yes, what type?:*____________________________
Heart	☐ Yes	☐ No	*If yes, what type?:*____________________________

Do you have a STENT? ☐ Yes ☐ No (please make copy of card)

Do you have a HEART VALVE? ☐ Yes ☐ No (please make copy of card)

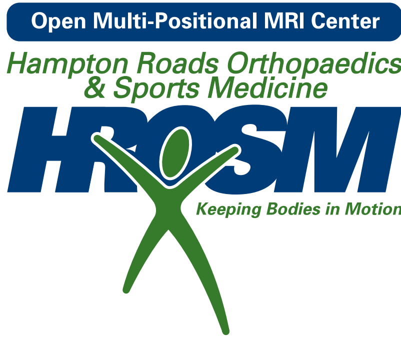
I verify that the answers I have provided to questions in this form are correct and I understand that withholding information may adversely affect the interpretation of this exam or could lead to injury or death.

Patient Signature:____ Date:____________________

MRI CANCELLATION POLICY

Please note that HROSM reserves the right to cancel or reschedule your appointment if you arrive 15 minutes late to your scheduled appointment without prior notification. Should you need to cancel or reschedule your appointment, please contact our office within 24 hours of your scheduled scan. If you cancel or reschedule within the specified 24 hour period, you will not be charged a cancellation fee. HROSM reserves the right to charge a $50.00 cancellation fee and may not reschedule your appointment at our facility.

Patient Signature:________________________________**Date:**__________________________________



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Brendan M. McConnell, D.P.M., F.A.C.F.A.S.
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Scott Bradley, M.D.
Rebecca Shoemaker, M.D.

Patient Data Sheet

The payment for services are due on the day services are rendered, unless other means of payment are agreed upon by the undersigned and HROSM/Open-Multi-Positional MRI Center and/or Radiology Specialists, PC. I authorize the filing of claims against any insurance in the force and any other third party payer including Champus, Medicare, or Workmen's Compensation carriers, and further assign and direct payment to HROSM/Open-Multi-Positional MRI Center and/or Radiology Specialists, PC. The undersigned understands that he/she is responsible for payment of any charges not covered by the assignment, and that any monies recovered in excess of the patient's indebtedness will be refunded. In the event of default on any payment due HROSM/Open-Multi-Positional MRI Center and/or Radiology Specialists, PC, I agree to pay all costs of collection as well as attorney's fee of 33-1/3%. I authorize the release of any medical information to process claims for services rendered.

I hereby authorize and direct that any balances due owing to HROSM/Open-Multi-Positional MRI Center and/or Radiology Specialists, PC will constitute a lien for their full amount as against any proceeds of insurance whether liability, medical payments coverage, or any settlements of any kind whatsoever, and I hereby authorize and direct my attorney or representative to honor this lien in full.

I agree to the above, authorize treatment, and acknowledge receipt of a copy of this agreement of my request and the payment and credit policy of HROSM/Open-Multi-Positional MRI Center and/or Radiology Specialists, PC.

Patient Signature:____ **Date:**____________________

Relationship to patient:__________________________________

AUTHORIZATION TO RELEASE MEDICAL RECORDS

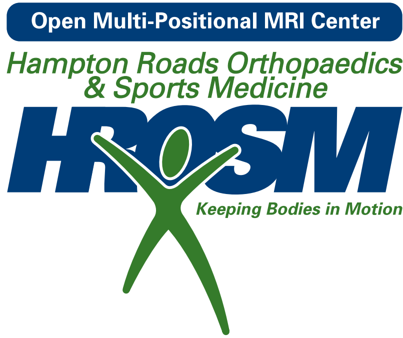
I hereby authorize the release of my medical records to any treating physician and /or therapist to prevent any delays in treatment that may occur.

Patient Signature:____ **Date:**____________________

READING OF MRI STUDY AND RELEASE

Your MRI study will be forwarded to Radiology Specialists, P.C. for interpretation. The above information will be forwarded for their billing purposes. We are advising you there will be two separate billing parts for your MRI scan: one from HROSM (technical) and one from Radiology Specialists, P.C. (reading of the study)

Patient Signature:____ **Date:**____________________



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Magnetic Resonance Imaging (MRI) Consent Form

____
Patient Name

The presence of body piercing jewelry that is made from ferromagnetic or conductive material may cause uncomfortable sensations from movement or displacement that may be mild to moderate depending on the site of the body piercing. In extreme cases, serious injuries may occur. Because of potential safety issues, metallic body piercing jewelry should be removed prior to entering the MRI environment.

☐ I confirm I have removed all my metallic or magnet objects, including keys, hairpins, barrettes, jewelry, watch, safety pins, paper clips, money clips, credit cards, coins, pens, belt, pocket knife to include any metal subcutaneous (beneath the skin) objects.

☐ I have answered all the questions on the MRI Screening Form to the best of my ability and understand that a possible injury could be a result of me withholding vital information.

I confirm with my signature below that I consent for an MRI.

______________________________	____________________
Patient's Signature	Date
If unable to give consent, consent obtained from:	
______________________________	____________________
Parent/Legal Guardian's Name	Date
______________________________	____________________
Witness (MRI Technician)	Date