

Open Multi-Positional MRI SCREENING SHEET

Date: _____

Patient Name: _____ Phone: _____ DOB: _____ Weight: _____

Referring Physician: _____

Is this your first MRI? **Yes** **No** *If NO, what is the date and locatin of your prior MRI? _____

Are you using a walker, wheelchair or cane? **Yes** **No**

If **YES**, Can you bear your own weight briefly without assistance **Yes** **No**

PLEASE MAKE SURE TO ANSWER ALL QUESTIONS BELOW

Do you have any of the following?

Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No
Implanted Cardiac Defibrillator	<input type="checkbox"/> Yes <input type="checkbox"/> No
Imbedded bullets,BBPellets,Shrapnel	<input type="checkbox"/> Yes <input type="checkbox"/> No
Brain Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No
Aneurysm Clips/Coils in Brain	<input type="checkbox"/> Yes <input type="checkbox"/> No
Electrical/Nerve/Spine Stimulators	<input type="checkbox"/> Yes <input type="checkbox"/> No
Infusion Pumps	<input type="checkbox"/> Yes <input type="checkbox"/> 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

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

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? *If yes, you may require an orbital x-ray 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: _____

Hampton Roads Orthopaedics & Sports Medicine

MRI Waiver

PAYMENT POLICY AND INSURANCE ASSIGNMENT RELEASE: The payment for services is due on the day services are rendered, unless other means of payment are agreed upon by the undersigned and Hampton Roads Orthopaedics & Sports Medicine or its affiliated service groups. I authorize the filing of claims (electronically and/or hard copy) against any insurance in force and other third party payer including Medicare, Medicaid, or Workers' Compensation carriers, and further assign direct payments to Hampton Roads Orthopaedics & Sports Medicine. The undersigned understands that he/she is responsible for payment of any charge not covered by this agreement, and that monies recovered in excess of the patients' indebtedness will be refunded. In the event of any default on any payment due Hampton Roads Orthopaedics & Sports Medicine and its affiliated service groups, I agree to pay all costs including 33 1/3% collections and attorney fees. I also authorized Hampton Roads Orthopaedics & Sports Medicine or agents to speak to me regarding my balance. I authorize the release of any medical information to process claims for services rendered I understand there is no guarantee of treatment outcomes.

INTERPRETATION: Your MRI films and billing information will be forwarded to Radiology Specialists, P.C. for interpretation. 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)

RELEASE OF PROTECTED HEALTH INFORMATION: Under the Federal HIPAA Privacy Rule, HROSM is not allowed to release specific patient information to other individuals or companies without authorization from the patient. This may include appointment and billing information as well as treatment information or copies of your medical records. If you wish to have your information released to individuals or companies (i.e. family members, physicians, attorneys, disability companies) please list these individuals below:

I authorize HROSM to release certain medical information about me to the following individuals or companies: Please note Full PHI will include any and all information: (including personal, health, demographics, claims, billing and medical records

I understand that this authorization expires one year from the date below.

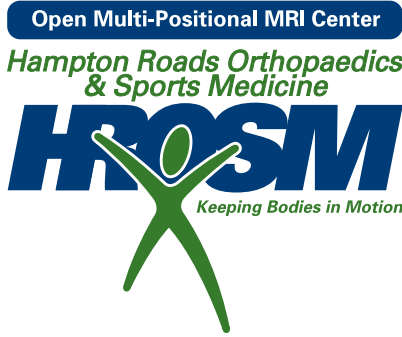
Name: _____ Full PHI Partial PHI

Name: _____ Full PHI Partial PHI

If Partial Information is checked please list the type of information you would like to share in the section below (such as specific treatments, dates of service or billing details):

Patient Signature: _____ Date: _____

Print Name: _____



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