# 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 | ☐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 |

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

### *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 |

**** Please note that if an exam is ordered with contrast, all labs need to be received within 48 hours of scan**

### *Arthrogram Screening*

Are you allergic to IODINE? ☐Yes ☐No

### *Females*

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

Are you nursing?: ☐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 <u>Partial Information</u> 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):**

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**Patient Signature:**_____ **Date:**_____

**Print Name:** _____

Open Multi-Positional MRI Center

Hampton Roads Orthopaedics & Sports Medicine

HROSM

Keeping Bodies in Motion

# 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