



MRI PATIENT HISTORY

Patient Name _____

Date _____

Sex: M F

Weight _____ Ht _____

D.O.B _____ Age _____

Referring Physician: _____

Reason you are here today? (Explain your medical problem in detail.... What is the problem? Where is the problem? How long have you had this problem?)

Is your problem related to an injury? Yes No If yes, Date of Injury? _____

Have you had a previous MRI or CT related to this exam? Yes No If Yes, please explain: _____

Have you taken any sedation today to relax you for this procedure? Yes No If Yes, what? _____

If yes, Do you have someone to drive you home? Yes No

Have you had an injury to the eye involving a metallic object or fragment? Yes No If Yes, please explain? _____



List any Drug Allergies: _____

List previous Surgeries: _____

Medications presently taking: _____



MRI Contrast History:

Have you ever had MRI contrast? Yes No Did you have any kind of reaction? Yes No If yes, explain: _____

Are you Breast feeding at this time? Yes No

Do you have anemia or any disease(s) that affect your blood, a history of renal disease, or seizures? Yes No If Yes, please explain? _____

Female Patients: Date of last menstrual period: ____/____/____



I have answered these questions to the best of my knowledge and understand the information presented to me. I have also informed the technologist that I am not pregnant at this time.

Patient/Parent/Legal Guardian

Technologist Signature

Date

Amount & type of Contrast

Lot Number

Expiration Date



Smart Choice MRI
Consent for Treatment and Financial Agreement

- A. Consent for Treatment: I am entering Smart Choice MRI for the purpose of medical and /or invasive treatment or diagnosis. I consent to my physician, consulting and /or referring physicians and their assistants and designees, and other facility personnel, to provide me with medical, diagnostic, or other treatment services judged necessary and/or appropriate by my physician. This includes my consent for such services as x-rays and laboratory tests, treatments or medication, monitoring and all other procedures or treatments that do not require my specific informed consent.
B. General Acknowledgment: I understand the practice of medicine is not an exact science. I understand that medical treatment and diagnosis may involve risk of injury and even death. No guarantees have been made to me with to the result of my examinations or treatments in the facility. I understand that the physicians at this facility are not employees or agents, but rather independent contractors who have been granted the privilege of using this facility for the care and treatment of their patients. I understand that the facility is not liable any actions or omission of, or instructions given by such independent contractors who treat me while I am in the facility. I understand that it is my responsibility to follow instructions and make arrangements for follow-up care. I understand that I may review and obtain a copy of my medical records at my own expense, and that this review shall take place in the facility, during regular business hours.
C. Assignment and Agreement to Pay: I understand that I am responsible for payment for the services that I receive and guarantee payment for these services. I hereby assign to the facility and the physicians and professionals associated with the facility, for application to my bill for services all rights and claim for reimbursement under federal or state healthcare plan (including but not limited to Medicare or Medicaid), insurance policy, any managed care arrangement or any other similar third party payer arrangement that covers health care costs and for which payment may be available to cover the cost of the services provided me. I understand that I am responsible for any applicable co-payment, deductible, co-insurance and /or noncovered cost and charges. I understand that not all insurance companies pay the usual and customary fees of the facility, the physician and /or the professionals associated with the facility. Therefore, when permitted by law, any outstanding balance will be my responsibility. I understand and agree that I am responsible for the cost of collection and/or reasonable attorney fees related to my account. I understand that my health information will be released to my insurers, payers, or other for billing purposes.
D. Privacy Notice: I understand that under the Health Insurance Portability & Accountability Act of 1996(HIPAA). I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:
a. Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
b. Obtain payment from third party payers
c. Conduct normal healthcare operations such as quality assessments and physician certification.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosure of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this facility at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you agree then you are bound to abide by such restriction.

Patient Name: _____

Home Address: _____

Patient's Signature: _____
(If patient is a minor, parent or guardian please sign)

Date: _____

Home Phone: (____) _____

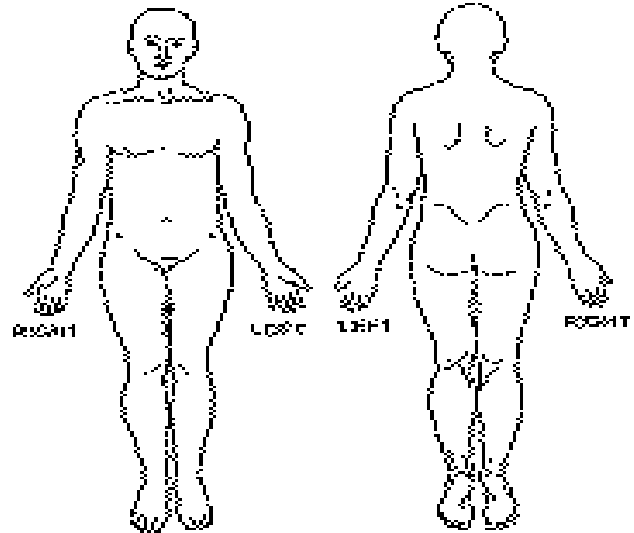


WARNING: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure (i.e., MRI, MR angiography, functional MRI, MR spectroscopy). Do not enter the MR system room or MR environment if you have any question or concern regarding an implant, device, or object. Consult the MRI Technologist or Radiologist **BEFORE** entering the MR system room. The MR system magnet is **ALWAYS** on.

Please indicate if you have any of the following:

- Yes No Aneurysm clip(s)
- Yes No Cardiac pacemaker
- Yes No Implanted cardioverter defibrillator (ICD)
- Yes No Electronic implant or device
- Yes No Magnetically-activated implant or device
- Yes No Neurostimulation system
- Yes No Spinal cord stimulator
- Yes No Internal electrodes or wires
- Yes No Bone growth/bone fusion stimulator
- Yes No Cochlear, otologic, or other ear implant
- Yes No Insulin or other infusion pump
- Yes No Implanted drug infusion device
- Yes No Any type of prosthesis (eye, penile, etc.)
- Yes No Heart valve prosthesis
- Yes No Eyelid spring or wire
- Yes No Artificial or prosthetic limb
- Yes No Metallic stent, filter, or coil
- Yes No Shunt (spinal or intraventricular)
- Yes No Vascular access port and/or catheter
- Yes No Radiation seeds or implants
- Yes No Swan-Ganz or thermodilution catheter
- Yes No Medication patch (Nicotine, Nitroglycerine)
- Yes No Any metallic fragment or foreign body
- Yes No Wire mesh implant
- Yes No Tissue expander (e.g., breast)
- Yes No Surgical staples, clips, or metallic sutures
- Yes No Joint replacement (hip, knee, etc.)
- Yes No Bone/joint pin, screw, nail, wire, plate, etc.
- Yes No IUD, diaphragm, or pessary
- Yes No Dentures or partial plates
- Yes No Tattoo or permanent makeup
- Yes No Body piercing jewelry
- Yes No Hearing aid
(Remove before entering MR system room)
- Yes No Other implant _____
- Yes No Breathing problem or motion disorder
- Yes No Claustrophobia

Please mark on the figure(s) below the location of any implant or metal inside of or on your body.



IMPORTANT INSTRUCTIONS

Before entering the MR environment or MR system room, you must remove all metallic objects including hearing aids, dentures, partial plates, keys, beeper, cell phone, eyeglasses, hair pins, barrettes, jewelry, body piercing jewelry, watch, safety pins, paperclips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clipper, tools, clothing with metal fasteners, & clothing with metallic threads.

Please consult the MRI Technologist or Radiologist if you have any question or concern **BEFORE** you enter the MR system room.

NOTE: You may be advised or required to wear earplugs or other hearing protection during the MR procedure to prevent possible problems or hazards related to acoustic noise.

I attest that the above information is correct to the best of my knowledge. I read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form and regarding the MR procedure that I am about to undergo.

Signature of Person Completing Form: _____ Date ____/____/____
Signature

Form Completed By: Patient Relative Nurse _____
Print name Relationship to patient

Form Information Reviewed By: _____
Print name Signature

MRI Technologist Nurse Radiologist Other _____