MRI PATIENT SCREENING

Patient Name _____MR#_____(OFFICE USE ONLY)

Social Security Number _____Date of Birth_____ Age_____ Weight_____

1. Yes	No	Do you have a pacemaker? If yes, STOP & NOTIFY SOMEONE!
2. Yes	No	Do you have pacemaker leads?
3. Yes	No	Have you ever had metal fragments in your eyes?
4. Yes	No	If "yes", have they been removed? When? _____
5. Yes	No	Have you ever had brain surgery?
6. Yes	No	If yes, do you have aneurysm/brain clips?
7. Yes	No	Have you had a tattoo or cosmetic coloring (example:eyelashes,eyeliner) in the past 12 months?
8. Yes	No	Have you ever been diagnosed or do you presently have Nephrogeniystemic Fibrosis (NSF)?
9. Yes	No	Have you ever had heart surgery?
10. Yes	No	If yes, do you have artificial heart valves?
11. Yes	No	Have you ever had inner ear surgery?
12. Yes	No	Do you have an IVC umbrella?
13. Yes	No	Do you have a neurostimulator device?
14. Yes	No	Are you wearing a pain patch?
15. Yes	No	Do you have removable dental work, i.e. dentures or partials?
16. Yes	No	Do you have asthma?
17. Yes	No	Are you claustrophobic?

THE FOLLOWING ITEMS CAN INTERFERE WITH MRI IMAGING, AND SOME MAY JEOPARDIZE YOUR SAFETY. PLEASE INDICATE WITH A CHECK MARK IF YOU HAVE ANY OF THESE ITEMS IN YOUR BODY.

_____	Aortic Clips	_____	Metal Joint Replacements
_____	Carotid Clips	_____	Bone or Joint Pins, Rods, or Screws
_____	Heart Valve Replacement	_____	Prosthesis
_____	Insulin Pump or Port	_____	Metal Mesh
_____	Infusion Pump (Porta Cath)	_____	Wire Sutures
_____	Hearing Aids	_____	Shrapnel/BB's/Buckshot
_____	Cochlear Implant in Ear	_____	Any other metal or foreign body
_____	Shunt in Brain	Describe _____	

Yes	No	Have you had X-rays of area we are scanning today?
		If Yes, when? _____ Where? _____
Yes	No	Have you had a previous MRI of the area we are scanning today?
		If Yes, when? _____ Where? _____
Yes	No	Do you, yourself, have a history of cancer?
		If yes, where? _____ Do you still have cancer? _____
Yes	No	Are you pregnant at this time?
Yes	No	Do you have an IUD? If yes, what kind? _____

How long have you had pain? _____ Where is it located?_____

Which side hurts worse? Right Left Both Weakness? Right Left

Numbness in your arms, hands, legs and feet? (please circle) Right Left Both

This procedure will be explained to you and all your questions addressed prior to the MRI scan.

I do not have a pacemaker, nor have I had surgery requiring aneurysm clips. I do not have cochlear implants in the ear, nor do I have metallic foreign bodies in the eye. I am fully aware that if I have any of the above, an MRI scan could be hazardous to my health. The above questions have been answered truthfully, and I agree to the MRI study.

Patient's Signature _____ Date _____

I have reviewed and assessed the patient: ___Y ___ N Tech Initials: _____

GAINESVILLE HIGH FIELD MRI

PATIENT INFORMATION

TODAY'S DATE: _____ MR#_____ (OFFICE USE ONLY)

PATIENT NAME: _____
LAST FIRST MIDDLE INITIAL

ADDRESS: _____ APT #: _____

CITY: _____ STATE: _____ ZIP: _____ EMAIL: _____

HOME TELEPHONE: _____ CELL TELEPHONE: _____ WORK: _____

DATE OF BIRTH: _____ SOCIAL SECURITY #:_____ SEX: _____ M_____F

EMPLOYER: _____ TELEPHONE #: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PRIMARY INSURANCE: _____ PHONE: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

POLICY #: _____ GROUP/PLAN #: _____

SECONDARY INSURANCE: _____ PHONE: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

POLICY #: _____ GROUP/PLAN #: _____

ATTORNEY NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP _____

TELEPHONE #: _____ FAX #: _____

REFERRING PHYSICIAN: _____ TELEPHONE #: _____

DO YOU HAVE A FOLLOW UP APPOINTMENT? IF YES, WHEN? _____

PRIMARY CARE PHYSICIAN: _____ TELEPHONE #: _____

WOULD YOU LIKE US TO SEND THIS MRI REPORT TO ANY DOCTOR NOT LISTED? _____

IS YOUR CONDITION RELATED TO:

EMPLOYMENT YES NO INJURY DATE: _____ CLAIM #: _____

ACCIDENT YES NO INJURY DATE: _____ CLAIM #: _____

HOW DID YOU HEAR ABOUT US? (PLEASE CHECK ALL THAT APPLY)

___RETURNING PATIENT ___PHYSICIAN ___WORD OF MOUTH ___SOCIAL MEDIA ___THE SKY 97.3 ___ESPN 98.1 ___98.5 KTK

OTHER PLEASE EXPLAIN _____

GAINESVILLE HIGH FIELD MRI
AUTHORIZATION FOR RELEASE OF INFORMATION

PLEASE PRINT

** Please tell us with whom we ***may*** discuss your protected health information:

(Example: spouse (name), children (name(s)), other relatives (name(s)), friends or caregivers (name(s))

Name: _____Relationship:_____

Name: _____Relationship:_____

Name: _____Relationship:_____

Please tell us with whom we ***may not* discuss your health information:

_____

_____

_____

I understand that I may revoke this authorization at any time by notifying the practice in writing, but if I do it won't have any effect on any actions they took before they received the revocation.

_____ _____
Patient/Guardian Signature Date

_____
Print name of Person Signing

**Expires one year from date of signature

**If other than the patient (Patient Name) _____ is signing, are you the legal guardian, custodian or have power of Attorney for this patient, for treatment, payment or healthcare operations? _____ Yes _____ No

GAINESVILLE HIGH FIELD MRI

MEDICAL CONSENT: I consent to the examination, treatment, and procedures, which may be performed during the visit, including emergency treatment, considered necessary by my physician.

RELEASE INFORMATION: I authorize the above named provider to release any information needed to process the claims in reference to the examination, treatment, or procedures rendered by the provider. I further permit a copy of this authorization to be used in place of the original. I authorize the above named provider to request any information/records from other medical providers needed to help the process of my medical claim with Gainesville High Field MRI.

FINANCIAL RESPONSIBILITY: I understand that payment is due in full at the time of service and if not, I acknowledge that I am responsible to make the appropriate financial arrangements including but not limited to facilitating my insurance benefits and/or making monthly payment arrangements. Should my account become delinquent or be referred to any third party collection efforts, I agree to pay all reasonable interest, attorney fees, court costs and/or collection expenses. I agree in order for Gainesville High Field MRI to collect any amounts I may owe, they may contact me by telephone at any telephone number associated with my account, including wireless telephone numbers, which could results in charges to me.

MEDICARE/MEDICAID BENEFITS ONLY: If applicable, I certify that the information given by me in applying for payment under Title XVIII and/or XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me, to release to the Social Security Administration or its intermediaries or carriers, any information needed to this or a related Medicare/Medicaid claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to Gainesville High Field MRI. I authorize the above named provider to submit to Medicare and/or Medicaid for payment on my behalf.

IRREVOCABLE PATIENT-ATTORNEY-HEALTHCARE PROVIDER LIEN (liability cases only): I authorize and direct my attorney to pay the above named provider directly and sums dues for medical services rendered to me. I direct my attorney to withhold such funds from any settlement, verdict or judgment that is rendered in my case. I hereby notify my attorney that I am giving the above named provider a lien on these benefits or settlement proceeds. In consideration for the above named provider waiting for payment, this lien is irrevocable and can be satisfied by full payment of all sums dues for medical services rendered. I authorize the above named provider to notify my attorney of this lien at the provider's discretion. I understand that any settlement, verdict or judgment proceeds cannot be disbursed to me without first satisfying this lien. Should a dispute arise regarding payment of my charges, I authorize and direct my attorney to hold all monies sufficient to satisfy this lien in escrow until the dispute can be resolved. I further understand that it would be a violation or my attorney's ethical duties to disburse these disputed funds prior to resolution to the lien dispute.

I have read this disclosure and I agree to the terms described above.

Patient Name (please print): _____ Date: _____

Patient Signature: _____

I, _____, have been informed of the Notice of Patient Privacy Practices made available by Gainesville High Field MRI.

Patient Signature: _____ Date: _____

ASSIGNMENT, LIEN AND AUTHORIZATION
INSURANCE BENEFITS

To Whom It May Concern:

I, _____, hereby authorize and direct you, my insurance company and/or my attorney, to pay directly to **Gainesville High Field MRI** ("Assignee") such sums as may be due and owing Assignee for services rendered me, both by reason of accident of illness, and by reason of any other bills that are due to Assignee, and to withhold such sums from any disability benefits, medical payment benefits, No-Fault benefits, or any other insurance benefits obligated to reimburse me or form any settlement, judgment or verdict on my behalf as may be necessary to adequately protect said Assignee. I hereby further give a lien to said Assignees against any and all insurance benefits named herein and any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries of illness for which I have been treated by Assignee. This is to act as an assignment of my right and benefits to the extent of the Assignee's services provided. **Further, I hereby instruct the insurance carrier to request that, in the event the subject medical services and/or benefits are disputed for any reason, the amount of benefits being claimed by Gainesville High Field MRI are to be held in escrow and not disbursed until the dispute is resolved.**

In the event my insurance company is obligated to make payments to me upon the charges made by Assignee for their services refused to make such payments, upon demand by me or Assignee, I hereby assign and transfer to Assignee any and all causes of action that I might have or that might exist in my favor against such company and authorize Assignee to prosecute said cause of action either in my name or in Assignee name and further I authorize Assignee to compromise, settle or otherwise resolve said claim or cause of action as they see fit.

I authorize Assignee to release any information pertinent to my case to any insurance company, adjuster or attorney to facilitate collection under this Assignment, Lien and Authorization, I agree that the above mentioned Assignee be given Special Power of Attorney to endorse/sign my name on all checks and claim forms for payment of my bill.

Dated this _____ day of _____, 20_____.

_____ _____

CLAIMANT/PATIENT SIGNATURE REQUIRED **Witness**