MRI PATIENT INFORMATION SCREENING

Patient Name: _____ DOB: _____ Age: _____ MR#: _____

Referring Physician: _____ Exam Ordered: _____

Describe your problem & how long you have had it? _____

_____

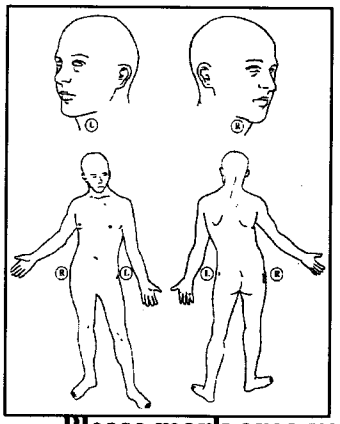
_____

Do you have any allergies? (circle one) Yes No
If yes, list: _____

Height_____ **Weight**_____

Have you had any previous related exams? (Please circle.)

MRI CT X-Rays Ultrasound Bonescan
If so, where? _____



Please mark area you're experiencing pain.

PROTOCOL

_____
_____
_____
_____
_____
_____
_____

Technologist Notes (to be completed by technologist)_____

_____

_____

The following questions are essential for the quality and safety of your MRI examination.

Do you have any of the following?					
Cardiac pacemaker	Yes	No	Liver problems	Yes	No
Aneurysm clip	Yes	No	VA/VP shunt	Yes	No
Cardiac pacer wire	Yes	No	Dental braces	Yes	No
Metal implant	Yes	No	Surgical staples	Yes	No
Cochlear/Ear implant	Yes	No	Insulin/drug pump	Yes	No
Shrapnel/bullet fragment	Yes	No	Orbital/eye prosthesis	Yes	No
Implanted bio-stimulator	Yes	No	Intravascular coil/stent	Yes	No
Neurostimulator	Yes	No	Internal electrodes	Yes	No
Metal worker	Yes	No	Penile Implant	Yes	No
Dialysis	Yes	No	Hearing Aid/dentures	Yes	No
HX renal failure or insufficiency	Yes	No	History of Chronic Kidney Disease	Yes	No
Transdermal Patch	Yes	No	Surgeries in area of scan	Yes	No
			Heart valve/Mechanical	Yes	No

Sometimes it is necessary to inject a special contrast material in the blood stream to improve the sensitivity of the MR exam. The drug is safe, but a small number of patients may be allergic to this drug.

I acknowledge that the above information is correct to the best of my knowledge. I have read and understand the entire contents of this form and have had the opportunity to ask questions regarding the information on this form. **I authorize the facility to perform the procedure ordered by my physician.**

Patient's/Guardian's Signature_____ Date_____

Technologist Signature_____ Date_____

FINANCIAL POLICY

The Radiologists and staff at Open MRI of Pueblo would like to welcome you to our Practice. We strive to provide you with excellent service and our goal is to make your visit as convenient as possible.

By signing below, you confirm that you have read this policy and understand that:

- It is your responsibility to inform our office of any address or telephone number changes.
- Your account is to be kept current – accordingly, all self-pay or insurance co-payments, co-insurances and deductibles will be collected at the time of service. Payable by cash, check, Visa, MasterCard, Discover or American Express.
- If you do not have your payment(s), your appointment may be rescheduled.
- You may be asked to schedule another appointment for issues other than the reason for your original appointment.
- A returned check will result in a $25 service charge ***and*** all future payments being required in the form of cash or credit card.
- You will only be sent a statement if your balance exceeds $5 and you will only receive a refund if the credit amount is over $10. Refunds will be issued within 4-6 weeks from the date requested, if there are no pending insurance claims.
- Any unpaid balances older than 30 days may be subject to 1.5% interest per month.
- If unable to keep your appointment, please notify us in advance so that we may offer that time to another patient. A pattern of repetitive "no shows" or late cancellations may regretfully result in an assessment of a cancellation/no show fee.
- The center provides one CD per patient for Images. There will be a $5 charge for each CD thereafter. There will be a charge for any Medical records or completion of paperwork.

If you have health insurance coverage:

We will submit your claims, however ***we must emphasize that as medical providers, our relationship is with you, <u>not</u> your insurance company.*** Although we attempt to verify your outpatient diagnostic testing benefits with your policy, please be advised this is only an estimate of your coverage based on the information given to us at the time of the inquiry.

By signing below, you confirm that you understand:

- It is your responsibility to inform us of any changes to your insurance policy so that your coverage can be re-verified prior to your appointment.
- If your insurance policy requires a referral from your primary care physicians, it is your responsibility to have that referral faxed to our office prior to your appointment.
- Not all services are a covered benefit with all insurance plans.
- It is your responsibility to be aware of what service(s) is being provided to you and if it is a covered benefit under your insurance policy.
- You are responsible for any non-covered charges not payable by your insurance policy.
- Although filing your insurance claims is a courtesy extended to you, all charges are always your responsibility from the date services are rendered.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we urge you to contact us promptly for assistance in the management of your account. If you have any questions about the above information, *please* do not hesitate to ask us. <u>We are here to help you</u>.

I have read and understand the above Financial Policy and agree to meet all financial obligations.

Patient Name (please print)	**Patient Signature**	**Date**
Responsible Party (other than patient – please print)	**Responsible Party Signature**	**Date**

Open MRI of Pueblo 1425 US 50 Highway, Pueblo, CO 81008 719-404-0991 Fax 719-404-0997
Visit us at <u>www.openmriofpueblo.com</u>

OPEN MRI OF PUEBLO

Last Name:_____ MI:_____ First Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Home#:_____ Work#:_____

Cell#:_____ Email Address:_____

SSN:_____ DOB:_____ Sex: ( ) Male ( ) Female

Marital Status: ( ) Single ( ) Married ( ) Widow ( ) Divorced

Employer Name:_____

Address:_____ Phone #:_____

Emergency Contact Name/ Relationship:_____ Phone#:_____

INSURANCE INFORMATION

(must indicate which insurance is responsible for payment of MRI procedure)

*Primary Insurance:*_____

*Secondary Insurance:*_____

*Work comp/Auto Insurance:*_____ *Date of Injury:*_____

*If work related list employer:*_____

1. **Patient Acknowledgement of Receipt of the Notice of Privacy Practices**

I acknowledge that I have received a copy of the Open MRI of Pueblo Notice of Privacy Practices.

_____ _____

Signature Date

_____

Print Name of Patient

If you are signing as the patient's representative:

_____

Printed name of representative

_____

Describe how you are the patient's representative (for Example: spouse, child, durable power of attorney for Healthcare – please provide a copy of the form, etc.)

2. **Authorization for Release of Medical Information**

I hereby give my permission for the person(s) listed below to receive information about my care,

NAME: RELATIONSHIP:

_____

_____

_____

Signature of Patient, or Guardian Date

_____ _____