

**Patient History, Authorization,
Consent & Screening Form**

For Office Use Only	PID:	Tech S/O _____
<input type="checkbox"/> Order	<input type="checkbox"/> History	<input type="checkbox"/> F/U Needed (see notes)

Name:		Date of Birth: Month _____ Day _____ Year _____		
Address:		City:	State:	ZIP:
Date:	Referring MD:		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Phone #(1) ()	Phone #(2) ()	Weight: _____ lbs	Height: _____ ft _____ in	
Reason for study & location of pain:				
What is your referring physician looking for?				

Please review and sign below. (If you are completing this form as the legal representative of the patient, your responses apply to you and the patient, as applicable.)

I. Exam-Related History

- Please check any of the symptoms you are currently experiencing.**

<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Blurred Vision	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Unexpected Weight Loss
<input type="checkbox"/> Headaches	<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Seizures	<input type="checkbox"/> Memory Loss	<input type="checkbox"/> Numbness (Right Side/Left Side)
<input type="checkbox"/> Nausea	<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Blackouts	<input type="checkbox"/> Pelvic Pain	<input type="checkbox"/> Weakness (Right Side/Left Side)
<input type="checkbox"/> Ringing in Ears	<input type="checkbox"/> Back Pain	<input type="checkbox"/> Other _____		
- How & when did these symptoms occur, e.g., injury, just started, etc.? _____
- Do you have, or have you had, any of the following?**

<input type="checkbox"/> Seizures	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Heart Arrhythmia	<input type="checkbox"/> Tumor, Lump, Mass	<input type="checkbox"/> Kidney/Renal Disease
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Multiple Myeloma	<input type="checkbox"/> Sickle Cell Anemia	<input type="checkbox"/> Congenital Heart Defect
<input type="checkbox"/> Stroke	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Bleeding Tendency	<input type="checkbox"/> Asthma/Bronchitis/Emphysema	
- List all history of cancer (DO NOT include family history).**
 Type: _____ Radiation or Chemotherapy? Yes No If yes, date of last treatment? _____
 In remission? Yes No Surgery? Yes No If yes, when & where? _____
- Have you had any tests pertaining to today's exam, e.g., MRI, CT or X-Ray?**
 Type? _____ When? _____ Where? _____
- Have you had any surgeries or therapies?** Yes No If yes:
 Type? _____ When? _____ Where? _____
- Do you have any food or drug allergies, e.g., medications, latex or seafood?** Yes No If yes:
 Please list: _____

II. Receipt of Notice of Privacy Practices Acknowledgement Form

I understand and agree that High Field & Open MRI:

- As part of my healthcare, originates and maintains health records describing my health history, symptoms, examination, test results, diagnosis, etc.;
- Has made available to me its Notice Regarding Privacy Rights;
- Has and reserves the right to change its Notice Regarding Privacy Rights, but that upon my request High Field & Open MRI will mail to me at the address above a copy of any revised Notice Regarding Privacy Rights prior to implementation.

➔ Patient Signature _____

III. Authorization, Assignment & Acknowledgment

- In relation to the procedure(s) ordered by my physician, I authorize (1) payment and assign any benefits under the terms of any insurance policy that may cover me to High Field & Open MRI; and (2) the release of any information to High Field & Open MRI that may have a bearing on benefits payable for the procedure(s) by any insurance company, prepayment organization, employer, hospital, physician, utilization review representative or any related entity or person;
- I authorize High Field & Open MRI (1) to contact my employer, insurer, guarantor, etc. for the purpose of determining the existence and extent of any insurance benefits; (2) to release to my insurer, current or subsequent physician, healthcare provider or facility all information that may have a bearing on either the procedure(s), my continuity of medical care, or any related benefits, without further consent from me;
- I understand that High Field & Open MRI is billing my insurance company as a courtesy to me;
- I also understand that High Field & Open MRI is not responsible for the loss of or damage to any of my personal possessions, including my money, jewelry or clothing, while I am in its facility; and
- I agree that (1) I am financially responsible for any charges not covered by my insurer(s), (2) should my account become delinquent, I will pay all reasonable costs incurred in any collection effort, including attorney fees; and (3) this authorization is effective for one year.

Medicare Patients:

- I request the payment of authorized Medicare benefits be made on my behalf to High Field & Open MRI for any services rendered by High Field & Open MRI;
- I authorize any holder of medical or other information about me to release to the Health Care Financing Administration or its agents, intermediaries or carriers any information needed to determine these benefits or the benefits payable for related services; and
- I understand that deductibles, coinsurances and any other charges not covered by Medicare are my responsibility.

➔ Patient Signature _____

IV. Consent to Procedure(s)

- I understand that my referring physician believes I should undergo the procedure(s) ordered to obtain additional information that may aid in diagnosing and treating my medical condition;
- My physician has fully explained to me and I understand the procedure(s) that will be performed, as well as all of the risks, benefits and any alternative procedures, including the risks and benefits of any contrast medium (*see Section VII for additional information*);
- I understand and have truthfully responded to the questions above, as well as the questions asked of me below;
- I understand that in spite of every skill and prudent effort made to avoid complications during the procedure(s) there is no guarantee a complication will not occur; and
- I authorize and give informed consent and authorize High Field & Open MRI to perform the procedure(s) ordered, including the injection of any contrast medium.

➔ Patient Signature _____

V. Information About Your Procedure



A. MRI (If you are having an MRI, please read section V(A))

Magnetic Resonance Imaging (MRI) is a diagnostic imaging procedure used to obtain additional information that may aid in diagnosing and treating certain medical conditions. MRI does not use x-rays or radiation. Instead, a magnetic field and radio waves are used to create an image of internal body structures.

Certain metallic implants, devices and objects may be very hazardous to you and may interfere with your MRI procedure. You must remove all metallic objects before entering the MR environment or MR system room. This includes:

- | | | | | | |
|----------------|--------------|-------------------|----------------|-----------------|--------------------|
| - hearing aids | - eyeglasses | - jewelry | - safety pins | - coins | - nail clippers |
| - beepers | - hair pins | (including body | - money clips | - pens | - steel-toed shoes |
| - cell phones | - barrettes | piercing jewelry) | - credit cards | - tools | - magnetic strip |
| - keys | - paperclips | - watches | - bank cards | - pocket knives | cards |

Loose metallic objects are especially dangerous and prohibited in the MR system room and MR environment. The MR scanner can be very loud. If this is a problem, notify the technologist immediately.

B. CT (If you are having a CT, please read section V(B))

Computed Tomography (CT) scanning is a medical test that helps physicians diagnose and treat medical conditions. It combines special x-ray equipment with sophisticated computers to produce multiple images or pictures of the inside of the body. CT scans of internal organs, bone, soft tissue and blood vessels provide greater clarity and reveal more details than regular x-ray exams.