MMR# _____ **OpenSided MRI Patient Packet** Date _____

PATIENT'S SSN# _____ PATIENT NAME _____
Last Name First Name Middle Initial

☐ Mr. ☐ Mrs.

☐ Ms. ☐ Miss Has your name changed since last visit? ◯ Yes ◯ No Previous Last Name _____

Sex: ☐ Male ☐ Female DOB _____ Age _____ Home Phone _____

Address _____ Apartment# _____

City/State/Zip _____

Patient's Employer _____ Occupation _____

Address _____ Suite# _____

City/State/Zip _____ Work Phone _____

Emergency Contact _____ Phone# _____

To the best of my knowledge there (is) ☐ (is not) ☐ any indication that I may now be pregnant . _____
INITIALS

PATIENT REFERRED BY DR. _____

**PERSON RESPONSIBLE FOR BILL, IF NOT PATIENT**

Patient's relationship to person responsible for bill ☐ Spouse ☐ Child ☐ Other

Name _____ Employer _____

Mailing Address _____ Mailing Address _____

City/State/Zip _____ City/State/Zip _____

Home Phone _____ Work Phone _____ Occupation _____

**INSURANCE AND/OR INJURY INFORMATION**

PRIMARY INSURANCE _____ Secondary Insurance _____

Group / Claim # _____ Subscriber Name _____

ID# _____ ID# _____

Employer# _____

IS THIS THE RESULT OF AN INJURY OR ACCIDENT? ☐ WORK RELATED ☐ OTHER ACCIDENT/INJURY ☐ AUTO ACCIDENT

Date of Accident _____ If Auto: Claim/Policy# _____

Brief summary of accident _____

**IF WORK RELATED INJURY: ( If this is a LABOR & INDUSTRIES claim please complete)**

Date of Injury _____ Cause of Injury _____

Employer at Time of Injury _____ Claim# _____

We keep a record of the health care services we provide you. You may ask us to see and copy that record. You may also ask us to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes and compels us to do so. You may see your record or get more information about it in this office.

Benefits are verified by your insurance carrier. This is not guarantee of payment, all charges are subject to insurance provisions. Finance charges are applied to all unpaid balances.

ASSIGNMENT AND RELEASE: I hereby authorize that my insurance benefits be paid directly to physician or facility. I am financially responsible for any balance due. I also authorize the Doctor or Insurance Company to release any information required to process this claim.

Signature _____ Date _____

The following items may become damaged or cause injury to others in a strong magnetic field.
THEY MUST NOT BE TAKEN INTO THE MRI SCAN ROOM.

| | | | |
|---|---|---|---|
| Hearing aid | Jewelry (rings, earrings, etc.) | Pager/cell phone | Belt buckle |
| Glasses | Wallet/money clip | Pocketknife | Bra/girdle/sanitary belt |
| Watch | Purse/pocket book | Credit or bank cards | Metal zippers/buttons |
| Safety pins | Pens/pencils | Artificial limb/prosthesis | |
| Hairpins/barrettes | Keys | Dentures/partial plates | |
| Wigs/hair pieces | Coins | Retainers | |

Patient Symptoms

Were they caused by an accident or injury? _____

I attest that the answers I have provided to the questions on this form are 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.

Signature (Patient or Guardian) _____ Date _____

NOT ALL EXAMS INVOLVE INJECTIONS, ONLY COMPLETE BOTTOM PORTION IF YOU ARE RECEIVING CONTRAST.
Your physician has referred you to us for an MRI examination involving an injection of gadolinium based contrast. This contrast may be beneficial in aiding the radiologist to interpret your images. We are prepared to treat any adverse reaction should it occur. Your physician is aware of the remote possibility of a complication and feels that the diagnostic information obtained far outweighs the minimal risk of the procedure. The percentage of any adverse reaction is < 5%.

INFORMED CONSENT FOR INTRAVENOUS CONTRAST INJECTION OF A GADOLINIUM BASED CONTRAST AGENT
For people with severely reduced kidney function, gadolinium contrast is considered a possible cause of a rare disease called nephrogenic systemic fibrosis (NSF). It is suggested that patients who receive hemodialysis treatment for renal failure should schedule their hemodialysis for 2 to 4 hours after gadolinium contrast injection. If you have renal failure but do not need dialysis, please tell the MRI technologist.

Weight lbs. _____

Have you ever had an allergic reaction to any type of contrast? If yes, please explain. ◯ Yes ◯ No

_____

Are you allergic to any medications? If yes, please explain. ◯ Yes ◯ No

_____

Have you ever had any (kidney) renal disease/failure or transplant? If yes, please explain. ◯ Yes ◯ No

_____

Have you ever had any liver disease/failure or transplant? If yes, please explain. ◯ Yes ◯ No

_____

Are you currently on dialysis? ◯ Yes ◯ No

Do you have diabetes? ◯ Yes ◯ No

Do you have a heart condition? ◯ Yes ◯ No

Do you have a history of asthma or emphysema? ◯ Yes ◯ No

Do you have a history of hypertension/high blood pressure? ◯ Yes ◯ No

I attest that the answers I have provided to the questions on this form are 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.

Signature (Patient or Guardian) _____ Date _____

Supervising Technologist _____

Name _____ DOB _____

ATTENTION: MRI PATIENTS AND ACCOMPANYING FAMILY MEMBERS

Patient safety is our primary concern. The MRI room contains a very strong magnet. Before you are allowed to enter, we must know if you have any metal in your body. Some metal objects can interfere with your scan or even be dangerous, so please answer the following questions carefully.

Have you ever had any of the following operations or surgical procedures? If yes, please explain.

- ☐ Eye Surgery
- ☐ Ear Surgery
- ☐ Heart Surgery
- ☐ Other: _____
- ☐ Orthopedic surgery
- ☐ Vascular surgery
- ☐ Back surgery

Date(s): _____

◯ Yes ◯ No Have you ever had any type of cancer? If so, please explain.

_____

◯ Yes ◯ No Have you ever been a machinist, welder, or metal-worker?

◯ Yes ◯ No Have you ever been hit in the face or eye with a piece of metal? (Including metal shavings, slivers, bullets, or BB's?)

◯ Yes ◯ No Have you ever had a piece of metal removed from your eye?

◯ Yes ◯ No Are you pregnant, possibly pregnant, or breast feeding?

Date of last menstrual period _____

DO YOU HAVE ANY OF THESE ITEMS IN YOUR BODY?

◯ Yes ◯ No Pacemaker, Wires, or defibrillator

◯ Yes ◯ No Brain aneurysm clips

◯ Yes ◯ No Ear Implant

◯ Yes ◯ No Eye Implant

◯ Yes ◯ No Electrical stimulator for nerves or bone

◯ Yes ◯ No Infusion pump

◯ Yes ◯ No Stents, coil filter, or wires in blood vessels

◯ Yes ◯ No Implanted catheter or tube

◯ Yes ◯ No Artificial heart valve

◯ Yes ◯ No Shunt

◯ Yes ◯ No Surgical clips, staples, wires, mesh, or sutures

◯ Yes ◯ No Orthopedic hardware(plates, screws, pins, rods, wires)?

◯ Yes ◯ No Artificial limb or joint

◯ Yes ◯ No Penile prothesis

◯ Yes ◯ No Magnetic implants anywhere

◯ Yes ◯ No Diaphragm or intrauterine device

◯ Yes ◯ No False teeth, retainers, or magnetic braces

◯ Yes ◯ No Permanent makeup(eye, brows,lips) body piercing and tattoos?

◯ Yes ◯ No Bullets, BB's or pellets

◯ Yes ◯ No Metal shrapnel or fragments

**Patient HIPAA consent form**

Consent for the use and disclosure of health information for treatment, payment or healthcare purposes.

I have obtained, read and understand the Notice of Privacy Practices for OpenSided MRI, which provides a complete description of information uses and disclosures.

I understand that:

- ✓ As a part of my healthcare, OpenSided MRI originates and stores paper and/or electronic records pertaining to my health care and health history, including symptoms, examination and test results, diagnoses and treatment.
- ✓ OpenSided MRI is not required to agree to the requested restrictions to the disclosure of your protected health information.
- ✓ I may revoke this consent, in writing, at any time with the exception of actions already taken. By refusal to sign or revoking of this consent form may result in dismissal of care or treatment as permitted by Section 164.506 in the Code of Federal Regulations.
- ✓ OpenSided MRI reserves the right to change their Notice of Privacy Practices, at any time as permitted by Section 164.520 in the Code of Federal Regulations. Should OpenSided MRI change their *Notice of Privacy Practices*, they will send a copy of the revised notice to the address I've provided.
- ✓ It may be necessary for the organization to disclose my protected health information to another entity for treatment, healthcare or billing and payment purposes and I allow OpenSided MRI to disclose this information to those entities.

I fully understand and accept the terms of this Patient HIPAA consent form. I acknowledge that I have received the *Notice of Privacy Practices* from OpenSided MRI and have had any and all questions regarding these forms answered by the undersigned employee.

Patient Signature _____ Date _____

**OFFICE USE ONLY**

☐ Patient consent received by _____ on _____

☐ Consent added to patient's medical record on _____

☐ Patient refused to sign consent _____

OpenSided MRI, LLC. employee signature _____