

Affordable Medical Imaging Patient Registration Form

PATIENT INFORMATION:

Patient's Name: _____

DOB: _____ Age: _____ Height (in): _____ Weight (lbs): _____ Gender: Male Female
Last First MI
(MM/DD/YYYY) (circle gender)

Address: _____

City: _____ State: _____ Zip Code: _____

Email: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

EMERGENCY CONTACT INFORMATION: HOW DID YOU HEAR ABOUT US? (Please circle your response)

Name: _____ Internet Newspaper Sign
Relation: _____ Phone book Friend/Co-worker TV
Phone: _____ Mailing Referring Physician
Radio Other _____

PHYSICIAN INFORMATION:

Referring Physician: _____

Clinic: _____

Phone: _____ Fax: _____

Primary Physician: _____

Clinic: _____

Phone: _____ Fax: _____

INSURANCE INFORMATION:

Provider: _____

Policy Number: _____

HIPAA PRIVACY PRACTICE NOTICE

Affordable Medical Imaging, LLC is required by law to maintain the privacy of, and provide individuals with, a notice of our legal duties and privacy practices with respect to protected health information. I have been informed by Affordable Medical Imaging, LLC of the Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. By signing my name below, I acknowledge that I have received this Notice of Privacy Practices for review and I understand and agree to its terms.

Patient Signature: _____ Date: _____

Staff Witness Signature: _____ Date: _____

AFFORDABLE MEDICAL IMAGING

Magnetic Resonance Imaging Patient Screening Form



WARNING: IF YOU HAVE A PACEMAKER, DEFIBRILLATOR OR ANEURYSM CLIP, DO NOT PROCEED WITH YOUR SCAN. PLEASE NOTIFY A STAFF MEMBER IMMEDIATELY.

Patient Name: _____ Today's Date: _____

Age: _____ Date of Birth: _____ Weight: _____ Gender: Male Female

1. Have you ever had a prior surgical procedure of any kind? Yes No

If yes, please indicate the date (approximate if unknown) and type of surgery: _____

2. Have you ever experienced any problem related to a previous MRI procedure? Yes No

If yes, please explain: _____

3. Do you have any respiratory concerns that could prevent you from having an MRI procedure? Yes No

If yes, please explain: _____

4. Have you ever been a welder, grinder, or sheet metal worker? Yes No

If yes, please explain: _____

5. Have you had an eye injury involving a metallic object or fragment (metallic slivers, shavings)? Yes No

If yes, please explain: _____

6. Have you ever been injured by a metallic object or foreign body (e.g., BB, bullet, shrapnel)? Yes No

If yes, please explain: _____

7. Have you recently had a small bowel endoscopy/colonoscopy in the past 30 days? Yes No

If yes, how recent: _____

8. Do you have anemia or any disease(s) that affects your blood, a history of renal (kidney) disease, renal (kidney) failure, renal (kidney) transplant, high blood pressure (hypertension), liver (hepatic) disease, or seizures? Yes No

If yes, please explain: _____

9. Do you have a history of asthma, allergic reaction, respiratory disease, or reaction to contrast medium or dye used for MRI, CT, or x-ray procedures? Yes No

If yes, please explain: _____

10. Have you ever had a reaction to or have been told that you should not have contrast medium injections for imaging studies? Yes No

If yes, please explain: _____

For Female Patients:

11. Are you or could you be pregnant or experiencing a late menstrual period? Yes No

12. Do you have a diaphragm/IUD in place? Yes No

13. Are you currently breastfeeding? Yes No



WARNING: IF YOU HAVE A PACEMAKER, DEFIBRILLATOR OR ANEURYSM CLIP, DO NOT PROCEED WITH YOUR SCAN. PLEASE NOTIFY A STAFF MEMBER IMMEDIATELY.

Please indicate if you currently have or ever had any of the following:

Aneurysm clip(s)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation seeds or implants	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cardiac pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swan-Ganz or thermodilution catheter	<input type="checkbox"/> Yes <input type="checkbox"/> No
Implanted cardioverter defibrillator (ICD)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Medical patch (transdermal)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Electronic implant or device	<input type="checkbox"/> Yes <input type="checkbox"/> No	(e.g., Nicotine, Nitroglycerine)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Magnetically activated implant or device	<input type="checkbox"/> Yes <input type="checkbox"/> No	Any metallic fragment or foreign body	<input type="checkbox"/> Yes <input type="checkbox"/> No
Neurostimulator (TENS unit)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Wire mesh implant	<input type="checkbox"/> Yes <input type="checkbox"/> No
Spinal cord stimulator	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tissue expander (e.g., breast)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bone growth/bone fusion stimulator	<input type="checkbox"/> Yes <input type="checkbox"/> No	Surgical staples, clips, or metallic sutures	<input type="checkbox"/> Yes <input type="checkbox"/> No
Internal electrodes or wires	<input type="checkbox"/> Yes <input type="checkbox"/> No	Joint replacement (hip, knee, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cochlear, otologic, or other ear implant	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bone/joint pin, screw, nail, wire, plate, etc.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Insulin or other infusion pump	<input type="checkbox"/> Yes <input type="checkbox"/> No	Intrauterine device (IUD), diaphragm or pessary	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any type of prosthesis (e.g., eye, penile)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Braces, dentures, or partial plates	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart valve prosthesis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tattoo or permanent makeup	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood clot filter	<input type="checkbox"/> Yes <input type="checkbox"/> No	Body piercing jewelry	<input type="checkbox"/> Yes <input type="checkbox"/> No
Eyelid spring or wire	<input type="checkbox"/> Yes <input type="checkbox"/> No	Wig or hair implants	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial or prosthetic limb	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hair accessories (e.g., hairpins)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Metallic stent, filter, or coil	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other implant	<input type="checkbox"/> Yes <input type="checkbox"/> No
Shunt (spinal or intraventricular)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Breathing problem or motion disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
Vascular access port and/or catheter (e.g. Broviac, Port-a-Cath, Hickman)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Claustrophobia	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Hearing aid	<input type="checkbox"/> Yes <input type="checkbox"/> No



IMPORTANT INSTRUCTIONS

Please remove all metallic objects before entering the MRI scan room, including the following: Jewelry (e.g., earrings, rings, body piercings), hairpins, hair clips, dentures, false teeth, partial dental plates, hearing aids, eyeglasses, watch, pager, cell phone, keys, safety pins, paper clips, money clip, any magnetic strip cards (e.g., bank, credit), coins, pens, pocketknife, nail clipper, tools, and clothing with metal fasteners or containing metal thread.

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

I have reviewed the above information and attest that the information is accurate to the best of my knowledge. I have read and understand the entire contents of this form and had the opportunity to ask questions regarding this information and the MRI procedure.

Patient Name (please print): _____

Patient Signature: _____ Date: _____

OFFICE USE ONLY

Gadolinium: _____ cc's Injection time: _____ Injection Site: _____ Technologist: _____

Physician signature: _____ Date: _____ Time: _____

My signature confirms that I have verbally ordered the above medication and/or IV.

Technologist Notes: _____



Payment Authorization Form

We appreciate you selecting Affordable Medical Imaging, LLC for your imaging exam. We will do everything we can to make your experience as comfortable and pleasant as possible. Please let us know if there is anything we can do to better serve your needs.

In order to achieve the goal of providing the best possible service to you at the lowest possible cost, full payment is due when services are rendered. We accept Visa, MasterCard, Discover, American Express and Debit Cards. We do not accept checks. The cost for a single MRI exam of any kind is \$395.00 plus \$50.00 for contrast. The cost for CT is \$350.00 plus \$75.00 for contrast. The cost for a single ultrasound exam of any kind is \$250.00. The cost for an Echocardiogram is \$295.00. The cost for a Vascular Screening is \$100.00.

If you intend to submit your paid receipt for reimbursement from your insurance company, you may need to contact your insurance company prior to having your exam.

Affordable Medical Imaging has partnered up with CareCredit to help with financial assistance. CareCredit application must be approved to use it same day. Please ask an associate for further details.

I, _____ hereby authorize Affordable Medical Imaging, LLC to charge a total of \$ _____ to my credit card or debit card for services rendered.

Signature: _____ Date: _____

OFFICE USE ONLY:

Name on Card: _____

Card Number: _____

Exp Date: _____ Card Security Code: _____

Card Zip Code: _____