Affordable Medical Imaging Patient Registration Form

PATIENT INFORMATION:

Patient's Name:

____
Last First MI

DOB: __________ Age: ____ Height (in): ________ Weight (lbs): __________ Gender: Male Female
(MM/DD/YYYY) (circle gender)

Address: ____

City: ____________________ State: ____________________ Zip Code: ____________

Email: ____

Home Phone: ____________ Work Phone: ____________ Cell Phone: ____________

EMERGENCY CONTACT INFORMATION:

Name: ______________________

Relation: ______________________

Phone: ______________________

HOW DID YOU HEAR ABOUT US? (Please circle your response)

Internet Newspaper Sign

Phone book Friend/Co-worker TV

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

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

Item	Yes	No
Aneurysm clip(s)	☐ Yes	☐ No
Cardiac pacemaker	☐ Yes	☐ No
Implanted cardioverter defibrillator (ICD)	☐ Yes	☐ No
Electronic implant or device	☐ Yes	☐ No
Magnetically activated implant or device	☐ Yes	☐ No
Neurostimulator (TENS unit)	☐ Yes	☐ No
Spinal cord stimulator	☐ Yes	☐ No
Bone growth/bone fusion stimulator	☐ Yes	☐ No
Internal electrodes or wires	☐ Yes	☐ No
Cochlear, otologic, or other ear implant	☐ Yes	☐ No
Insulin or other infusion pump	☐ Yes	☐ No
Any type of prosthesis (e.g., eye, penile)	☐ Yes	☐ No
Heart valve prosthesis	☐ Yes	☐ No
Blood clot filter	☐ Yes	☐ No
Eyelid spring or wire	☐ Yes	☐ No
Artificial or prosthetic limb	☐ Yes	☐ No
Metallic stent, filter, or coil	☐ Yes	☐ No
Shunt (spinal or intraventricular)	☐ Yes	☐ No
Vascular access port and/or catheter (e.g. Broviac, Port-a-Cath, Hickman)	☐ Yes	☐ No
Radiation seeds or implants	☐ Yes	☐ No
Swan-Ganz or thermodilution catheter	☐ Yes	☐ No
Medical patch (transdermal) (e.g., Nicotine, Nitroglycerine)	☐ Yes	☐ No
Any metallic fragment or foreign body	☐ Yes	☐ No
Wire mesh implant	☐ Yes	☐ No
Tissue expander (e.g., breast)	☐ Yes	☐ No
Surgical staples, clips, or metallic sutures	☐ Yes	☐ No
Joint replacement (hip, knee, etc.)	☐ Yes	☐ No
Bone/joint pin, screw, nail, wire, plate, etc.	☐ Yes	☐ No
Intruaterine device (IUD), diaphragm or pessary	☐ Yes	☐ No
Braces, dentures, or partial plates	☐ Yes	☐ No
Tattoo or permanent makeup	☐ Yes	☐ No
Body piercing jewelry	☐ Yes	☐ No
Wig or hair implants	☐ Yes	☐ No
Hair accessories (e.g., hairpins)	☐ Yes	☐ No
Other implant	☐ Yes	☐ No
Breathing problem or motion disorder	☐ Yes	☐ No
Claustrophobia	☐ Yes	☐ No
Hearing aid	☐ Yes	☐ 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, flase 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 accept checks ($35.00 returned check fee). The cost for a single MRI exam of any kind is $449.00 plus $150.00 for contrast. The cost for CT is $350.00 plus $150.00 for contrast. The cost for a single ultrasound exam of any kind is $250.00. The cost for an Echocardiogram is $495.00. 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: _______________

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