UNIVERSAL IMAGING CENTER

Magnetic resonance (MR) Procedure Screening Form for Patients

PATIENT REGISTRATION

Patient Name:	Sex: ☐ Male ☐ Female
Address:	
City/State/Zip:	Date of Birth:
Phone:	Social Security #:

EMERGENCY CONTACT INFORMATION

Contact Name:	Phone:	Relationship:

If minor, please provide parent/guardian information below:

Name:		Date of Birth:
Address:		City:
State:	Zip:	Phone:

INSURANCE : ☐ PRIVATE ☐ MEDICARE ☐ WC

Primary Insurance Name:	Secondary Insurance Name:
Mem ID/Claim #:	Mem ID/Claim #:
Adjustor Name:	Adjustor Name:
Adjustor Phone No.:	Adjustor Phone No.:
Date of Accident:	Employer Name:

PERSONAL INJURY: ☐ AUTO ☐ SLIP & FALL ☐ OTHER

Date of Injury:

Attorney Name:	Phone:
Attorney Address:	

I hereby authorize and direct my insurance carrier to pay directly to this provider of medical services any benefits due under my insurance plan. I agree to pay the balance of charges not paid under my plan. I also hereby authorize this provider to use, disclose or obtain any of my personal health information for treatment and payment. If I am UNINSURED, I understand I am fully responsible for all charges.

_____ _____

Patient's Signature Date

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Name:	Date:
Height: Weight:	Age:

1. Body Part to be examined:_____
2. Have you taken sedation/alcohol today to relax you for this procedure? Yes/No If so, what?
   _____
3. List any DRUG allergies:_____
4. List any medication you are PRESENTLY taking:_____
5. List any previous Surgeries:_____
6. List any prior imaging studies you have had on this body part:

Yes No Cardiac Pacemaker	**Yes No** Ear Surgery: Cochlear Implant/Stapes Prothesis/ Hearing Aid
Yes No Heart Surgery/Heart Valve	**Yes No** Vascular Access Port/Catheter
Yes No Implanted Cardiac Defibrillator (ICD)	**Yes No** Metal Mesh implants/Wire Staples or Clips/ Internal Electrodes
Yes No Brain Aneurysm Clips/Brain Surgery	**Yes No** Electrical/Mechanical/Magnetic Implants
Yes No Shunts/Stents/Filters/Intravascular Coil	**Yes No** Implanted Drug Infusion Pump/Medication Patch
Yes No Eye Surgery/Implants/Spring/Wires/Retinal Tack	**Yes No** Tissue Expander (Eg. Breast)
Yes No Dentures/Partials/Dental Implants	**Yes No** Are you pregnant? **Yes No** IUD? Date of last menstrual period
Yes No Orthopedic pins/Screws/Rods/Joints Prosthesis	**Yes No** Tattoos/Permanent Make-up/Body Piercing/ Patches
Yes No Neurostimulator/Biostimulator	**Yes No** Injury to the eye involving metal or metal shavings
Yes No History of Cancer or Tumor	**Yes No** Gunshot Wounds/Shrapnel/BB
Yes No Previous Back/Neck Surgery	**Yes No** Do you have pins in your hair/Clothes/Hair Extensions/Hair Pieces/Wig

MRI CONTRAST HISTORY

Yes No Have you ever had MRI Contrast?	**Yes No** Do you have history of Hypertension?
Yes No Did you have any kind of reaction?	**Yes No** Do you have diabetes?
Yes No Are you breast feeding at this time?	**Yes No** Do you have history of Respiratory disease?
Yes No Do you have history of renal disease?	**Yes No** Have you ever had severe hepatic disease, liver transplant or pending liver transplant?

I attest that the above information is correct to the best of my knowledge. I have also informed the technologist that I am not pregnant at this time and I give consent to have a contrast agent administered to me if needed for proper diagnosis of my procedure. I acknowledge that I am aware of the possibility of side effects with contrast and I have had the opportunity to ask question related to this form. I have had the opportunity to ask questions regarding the MRI procedure and I understand the information presented to me.

_____ _____ _____

Patient/Parent/Legal Guardian **MRI Technologist Signature** **Date**

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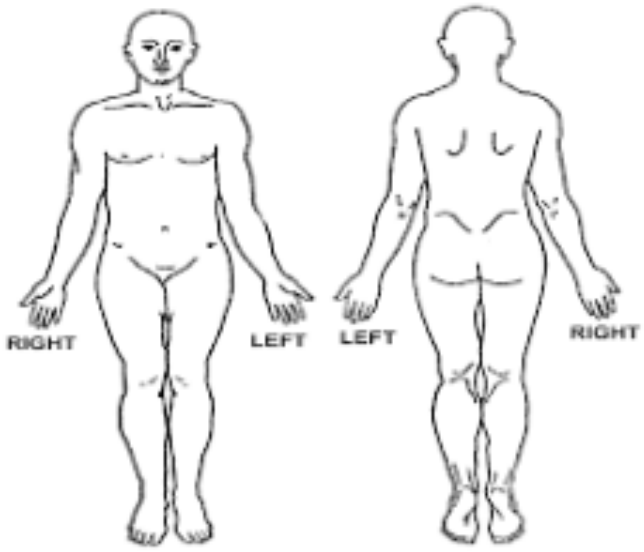
IMPORTANT INSTRUCTIONS

Before entering the MR environment or MR system room, you must remove ALL metallic objects including cell phones, ALL JEWELRY, hearing aids, dentures, partial plates, keys, eyeglasses, hair pins, barrettes, body piercings, watches, safety pins, paperclips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clipper, tools. Please consult the MRI Technologist or Radiologist if you have any question or concern BEFORE YOU ENTER THE MRI SYSTEM ROOM. Lockers will be provided before entering the MRI Suite (Glasses, dental work, shoes can remain with you until you enter the room). For your safety, you will be asked to change into a gown. Nothing should enter the examination room that can be attracted to a magnet. All persons entering the examination room should review and identify any possible reasons prior to entering the MRI scan room.

PLEASE MARK ON THE FIGURE BELOW THE LOCATION OF YOUR PAIN AND/OR DISCOMFORT:



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

Technologist Notes:_____

_____

_____

_____

_____

_____

_____ _____ _____

Technologist Name **Technologist Signature** **Date**

5757 WILSHIRE BLVD STE. 100 LOS ANGELES, CA 90036 PHONE: 323.648.0500 FAX: 323.648.0508

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FINANCIAL POLICY

Patient Name:	Date:

Patients with Insurance:

1. We will **only** bill the insurance presented at the time of service.
2. You are expected to pay any **known** co-pays, applicable deductibles and estimated amounts of co-insurance at the time of service.
3. It is your responsibility to know your insurance benefits, assure payments of insurance benefits to us and negotiate with your insurance company over dispute claims.
4. We require you as a patient to be responsible for any balance your insurance does not pay.
5. Any balances owed must be paid within 90 days to avoid further collection activity.

Self-Pay Patients:

1. Full cash payments are expected at time of service.
2. We **will not** bill insurance at a later date once cash pay has been accepted.

Delinquent Accounts:

1. You will receive periodic statements for outstanding balances.
2. Your account may be turned over to a professional agency specializing in debt collection for continued nonpayment.
3. Once your account is turned over to a collection agency for nonpayment, you will be responsible for any fees accrued by the collection agency during the collection process on your account.
4. We will not be able to see you for any future appointments until **all past due fees** are paid in full.

CD Images:

1. 1st CD copy is free.
2. 2nd CD copy or more, $15 each.

Forms of Payment:

1. We accept cash, checks, and Visa/Mastercard credit/debit cards.
2. There will be a $25 charge on all returned checks.

I certify that I have read and agree to the Financial Policies of Universal Imaging Center.

_____ _____

Signature **Date**

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PRIVACY POLICY

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. All of our employees, managers and doctors continually undergo HIPAA training. It is our policy to properly determine appropriate use of PHI in accordance with the government rules, laws and regulations. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

You may **refuse** to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent, at some future time you may request to refuse all or part of your consent. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

FOR MORE INFORMATION OR O REPORT A PROBLEM

If you have questions and would like additional information, you can file a complaint with this practice's Privacy Officer or with the office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a company with either the Privacy Officer or the Office for Civil Rights.

The address for OCR is listed below:

Office for Civil Rights
U.S. Department of Health & Human Services 200 Independence Avenue, S.W.
Room 509 F, H Building
Washington, D.C. 20201

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

AUTHORIZATION

I authorize the release of any medical information necessary for treatment by my current or future physician or health care provider. I further understand that this information may be transmitted electronically. Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure, in some cases, is not protected by California law and may no longer be protected by federal confidentiality law (HIPAA). I authorize Universal Imaging Center to release to my insurance company any medical information which may be necessary to process my insurance claim. I authorize the release of information necessary to process this claim and assign benefits payable for services directly to Universal Imaging Center. This assignment will remain in effect until revoked by me in writing. A copy of this assignment is to be considered as valid as the original. If I receive an insurance payment directly, I agree to make full payment immediately to Universal Imaging Center. I understand that in the event my insurance company denies this claim, I will be held financially responsible for all charges when applicable.

REQUEST FOR MEDICAL RECORDS POLICY

Any patient has the right to request medical records. All efforts will be made to handle each request in a timely manner. Due to patient load, privacy issues and obtaining accurate information, we will require 48 HOUR NOTICE to process your request. All requests must be made in writing with specific items requested.

Patient Name:	**Date:**
Signature:	