TEXAS**MRI**

MRI PATIENT QUESTIONNAIRE

EXAM: ______________________________

DATE OF STUDY: ______________________________

PATIENT NAME: ______________________________ AGE: __________ WEIGHT: __________

ORDERING PROVIDER: ______________________________ DOB: __________

Before we perform your MRI exam, we must know the following information about your health. If you need help answering any of these questions, please ask the technologist for assistance.

Why are you having this MRI scan? ______________________________

____

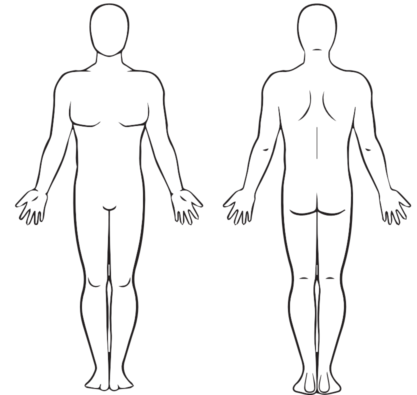
Please list previous exams performed for this problem (i.e. x-rays, CT, US Nuc. Med, or prior MRI:

____

____

FEMALE PATIENTS ONLY

Are you, or could you be, pregnant?	**YES** ☐	☐ **NO**
Are you breast feeding?	**YES** ☐	☐ **NO**



Please mark on the diagram(s) the location of any ***implants*** or ***metal*** inside of or on your body:

Please check all that apply:

Aneurysm Clips	**YES** ☐	☐ **NO**
Cardiac Pacemaker	**YES** ☐	☐ **NO**
Implanted Cardioverter Defibrillator	**YES** ☐	☐ **NO**
Electronic Implant or Device	**YES** ☐	☐ **NO**
Magnetically-Activated Implant or Device	**YES** ☐	☐ **NO**
Neurostimulation System	**YES** ☐	☐ **NO**
Spinal Cord Stimulator	**YES** ☐	☐ **NO**
internal Electrodes or Wires	**YES** ☐	☐ **NO**
Bone Growth/Bone Fusion Stimulator	**YES** ☐	☐ **NO**
Cochlear, Otologic or Other Ear Implant	**YES** ☐	☐ **NO**
Insulin or Other Infusion Pump	**YES** ☐	☐ **NO**
Implanted Drug Infusion Device	**YES** ☐	☐ **NO**
any Type of Prosthesis (Eye, Penile, Etc.)	**YES** ☐	☐ **NO**
Heart Valve Prosthesis	**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	**YES** ☐	☐ **NO**
Radiation Seeds or Implants	**YES** ☐	☐ **NO**
Swan-Ganz or Thermodilution Cath	**YES** ☐	☐ **NO**
Medication Patch (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 (I.E., Hip, Knee, Etc.)	**YES** ☐	☐ **NO**
Bone/Joint Pin, Screw, Nail, Wire, Plate, Etc.	**YES** ☐	☐ **NO**
Iud, Diaphragm, or Pessary	**YES** ☐	☐ **NO**
Dentures or Partial Plates	**YES** ☐	☐ **NO**
Tattoo or Permanent Makeup	**YES** ☐	☐ **NO**
Body Piercing Jewelry	**YES** ☐	☐ **NO**
Hearing Aid **(Remove Before Exam)**	**YES** ☐	☐ **NO**
Breathing Problem or Motion Disorder	**YES** ☐	☐ **NO**
Claustrophobia	**YES** ☐	☐ **NO**

Other Implant: ______________________________

I ATTEST THAT THE INFORMATION PROVIDED ON THIS FORM IS TRUE TO THE BEST OF MY KNOWLEDGE.

Patient/Parent or Legal Guardian Signature: ______________________________

INFORMED CONSENT FOR MRI WITH OR WITHOUT CONTRAST INJECTION

Patient Name: ______________________________ Date: ______________

I, the undersigned, being either the patient named above or legally authorized representative of the patient named above, do hereby consent to the performance of medical diagnostic and imaging procedures at Texas MRI, on the terms and conditions more fully set out below. I understand that I have the right to be informed about the diagnostic imaging procedure being used so that I may make the decision whether or not to undergo the procedure.

1. **Consent to Imaging Procedure:**

   Your attending physician believes it beneficial for you to undergo a diagnostic imaging procedure known as magnetic resonance imaging (MRI) to obtain additional information that may aid in diagnosing and treating your medical condition. It has been explained to me that 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. MRI is a painless procedure that only requires that you lie quietly on a padded table that gently glides you into the magnet. While the scanner is performing your scan, you will hear some humming and thumping sounds. These are normal and should not worry you. In some cases, a contrast agent may be injected into your vein in order to give a clearer image of the area being examined. The MRI study may be conducted without the injection of contrast, but the images may not be as helpful to the radiologist and your physician. Inform the technologist if you wish to refuse the contrast injection.

2. Because of the magnetic field and radio frequencies, people with a heart pacemaker, brain aneurysm clips, and some implanted metallic or electrical devices should not have an MRI. It is important that you inform the technologist if you are pregnant or think that you may be pregnant.

3. **Potential Risks:**

   Anytime an injection is given there is the potential for bruising or swelling at the injection site. Occasionally, minor allergic reactions occur in the form of itching, sneezing, hives, swelling of the eyes, wheezing or nausea. These symptoms may require treatment with medication we have at hand. Rarely, a more serious reaction may occur. A radiologist will evaluate the situation and determine if additional medical treatment is necessary. Even though it is rare, medical statistics indicated that a fatality might occur from the injection of contrast. If you have sickle cell anemia or kidney disorder, are pregnant or breast feeding, you **MUST** inform the technologist. **DO NOT BREAST FEED FOR 24 HOURS AFTER THE CONTRAST INJECTION.**

4. Blood Laboratory results may be needed before we can perform this exam. If we are unable to obtain lab results from your physician that are no greater than 6 weeks old, the Blood Lab testing will be required prior to your exam.

5. The benefit of this exam is to assist your physician with making a diagnosis. There may be other imaging alternatives, however your physician believes the MRI to be the best diagnostic test for you, after evaluating your symptoms and medical condition.

By my signature below, I hereby certify that I have fully read this consent, had it explained to me or have had it read to me. I have been given an opportunity to ask questions about my condition, alternative forms of treatment, and the procedures to be used, and the risks and hazards involved. I understand its contents and have sufficient information to give this informed consent.

Patient/Parent/Legal Guardian Signature: ______________________________

Technologist Signature: ______________________________

PLEASE PRINT

Patient's Legal First Name: ____________________ MI:________ Last:____________________

Date of Birth: _____/_____/_____ Age: ________ Marital Status: ______________ Sex: M F

Email Address: ______________________________ Social Security #: _______/_____/_______

Mailing Address: ____________________ City:____________________ State: _____ Zip: ______

Home Phone: ________________ Cell Phone: ________________ Work Phone: ________________

Current Employer: ____________________ Employer Address: ____________________

Employer Phone: ____________________ Occupation: ____________________

Body Part Being Scanned: ______________________________

If a result of an injury, where did it occur? ☐ YES ☐ NO If yes, date of injury: _____/_____/_____

☐ Home ☐ Liability ☐ Motor Vehicle ☐ Job ☐ Sport, Type: ____________________

FINANCIAL RESPONSIBILITY *(if Minor / Student)*

Responsible Party's Name: ____________________ Relationship: ____________________

Social Security #: ______/______/______ Date of Birth: _____/______/_____

Address: ____________________ City: ________________ State: ________ Zip: _________

Home Phone: ____________________ Cell Phone: ____________________

Email Address: ______________________________

INSURANCE INFORMATION

☐ **Same as Above**

Subscriber Name: ____________________ Relationship: ____________________

Social Security #: ______/______/______ Date of Birth: _____/______/_____

Subscriber's Employer: ____________________ Business Address: ____________________

Plan Name: ____________________ Policy/ID #: ____________________

Group #: ____________________

EMERGENCY CONTACT (someone not living in your household)

Name: ____________________ Relationship: ____________________

Phone Number: ____________________

Patient/Parent/Legal Guardian Signature: ______________________________ Date: ______________

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I, ____ , acknowledge that I have received a copy and have reviewed Texas MRI, Notice of Privacy Practices. This Notice describes how Texas MRI, may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information and my rights regarding my protected health information.

Patient/Parent/Legal Guardian Signature: ____________________________________ Date: ____________________

Please indicate any persons authorized to discuss your PHI with our office or those who are authorized to receive copies of your medical records. Include the person's name and relationship to yourself. Include a start date and end date to set restrictions of any individual(s).

Name	Relationship	Start Date	End Date
Name	Relationship	Start Date	End Date
Name	Relationship	Start Date	End Date

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment, Payment, Health Care Operations

Treatment
We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, if necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment
Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations
We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We May use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

Disclosures That Can Be Made Without Your Authorization

These situations include:

- As Required by Law
- Public Health issues as required by law
- Communicable Diseases
- Health Oversight
- Abuse or Neglect
- Food and Drug Administration requirements
- Legal Proceedings
- Law Enforcement
- Coroners, Funeral Directors and Organ donation
- Research
- Criminal Activity
- Military Activity and National Security
- Worker's Compensation
- Inmates
- Required Uses and Disclosures

Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your Consent, Authorization or Opportunity to object unless required by law. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively (i.e. electronically).

You may have the right to have our physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, or your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information.

This notice was published and becomes effective on/or before **April 14, 2003.**

Questions and Contact Person for Requests

If you have any questions or want to make a request pursuant to the rights described above, please contact:

HIPAA Compliance Officer
℅ Texas MRI
3720 20th Street
Lubbock, TX 79410
(806)792-6736 (Phone)
(806)792-6748 (Fax)

Assignment of Benefits

I hereby assign all medical benefits to which I might be entitled, including Medicare, Private Insurance, Liability, Worker's Compensation and all other health plans to Texas MRI, for services provided and not yet paid in full.

Release of Information

I hereby authorize Texas MRI, to disclose all or any part of my medical records or other medical information about me to any organization needing such information to determine benefits or process benefits payable for services provided.

Payment Policy

I understand that all medical charges incurred by me, or my dependents, for services rendered are my financial responsibility and that all fees necessary to collect this amount are payable by me.

Patients who have insurance coverage with a health plan that their physician is a contracted participating provider for (i.e. Medicare, Worker's Compensation, Medicaid, and some managed care plans) are responsible for payment of any deductible, co-payments, and non-covered services. Insurance claims will be filed for patients.

Unless prior arrangements have been made, patients covered by other health plans or without insurance are responsible for payment in full at the time of service.

Financial Responsibility

I am responsible for making satisfactory arrangements regarding payment of fees. I understand that insurance is a contract between me and my insurance carrier. **Although our office may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits.** You therefore agree to pay any portion of the charges not covered by insurance. Any such balance is NOT the responsibility of Texas MRI.

If in the event my insurance company fails to make payments for services rendered within sixty (60) days of billing, I will become personally responsible.

If this account is turned over for collections, I will be responsible for all collection fees, court costs, reasonable attorney's fees, interest and any other charges in regard to collecting the balance.

I have read and understand the financial responsibility of Texas MRI, and I agree to be bound by its terms.

______________________________ ______/______/______

Printed Name Social Security Number

______________________________ ______/______/______

Signature Date

ATTENTION

If you, or a person entering the scan room, have an implanted medical device, you must verbally communicate that to the MRI or CT technician before you have your scan or enter the scan room.

IMPORTANT INSTRUCTIONS

Remove all metallic objects before entering the MR environment or MR system room including Bobby Pins, Barrettes, Hair Pins, Magnetic Eye Lashes, Hearing Aids and Jewelry *(including body piercing). Loose metallic objects are especially prohibited in the MR system room and MR environment.

Please consult the MRI Technologist if you have any other questions or concerns BEFORE you enter the MR system room.

Patient/Parent/Legal Guardian Signature: ______________________ Date: ____________