MRI PRE-SCREENING FORM

OPEN MRI SOLUTIONS

Name: _____ DOB: _____ ID#: _____

Sex: Male Female Height: _____ Weight: _____

THE FOLLOWING ITEMS CAN INTERFERE WITH THE MRI EXAM AND COULD BE HAZARDOUS TO YOU. THEREFORE, PLEASE ANSWER THE FOLLOWING QUESTIONS.

Have you had any of the following surgeries:		
Brain Surgery:	YES	NO
Heart Surgery:	YES	NO
Eye Surgery:	YES	NO
Ear Surgery:	YES	NO
Do you have any of the following in your body:		
Pacemaker:	YES	NO
Artificial Limbs:	YES	NO
Neuro-Stimulator:	YES	NO
Metallic Implants:	YES	NO
Artificial Cardiac Valve/Stents:	YES	NO
Hearing Aid/Cochlear Implant:	YES	NO
Aneurysm/Cerebral Clips:	YES	NO

Are you claustrophobic?	YES	NO
Ever had or have following metal fragments in your body:		
Shrapnel, bullets, etc.:	YES	NO
Have you ever had an eye injury involving any of the following metal objects:		
Metallic slivers, shavings, etc.:	YES	NO
List any other allergies:		
Do you yourself have a history of cancer?	YES	NO
If yes, explain:		
FOR FEMALES ONLY: LMP?		
Are you pregnant or possibly pregnant?	YES	NO
Breastfeeding?	YES	NO

I VERIFY THAT THE ABOVE INFORMATION IS CORRECT

Signature: _____ Date: _____

FOR CONTRAST INJECTION STUDIES ONLY

Because of either your medical history or previous diagnostic tests, an injection with MRI *contrast media* may be helpful to determine further treatment/diagnosis. The *contrast media* used is Gadolinium (Gadopentetate Dimeglumine) and has been approved by the FDA for use in a clinical setting. Serious complications have not been reported after many uses of said media in FDA trials. Occasionally mild reactions such as a transient headache or mild nausea will occur.

Gadolinium may not be used for your exam if you have a medical history of the following:

Acute or Chronic Kidney Failure:	YES	NO	Removal of Kidney:	YES	NO
Kidney Dialysis:	YES	NO	Hemolytic Anemia:	YES	NO
Kidney Medication:	YES	NO	Liver Disease:	YES	NO
Diabetes:	YES	NO			

YOUR SIGNATURE IS REQUIRED TO ALLOW US TO USE CONTRAST MEDIA

Signature: _____ Date: _____

FOR INTERNAL USE

NOTES: _____

_____

Patient tolerated procedure well: YES NO

Dotarem lot #: _____ Exp: _____ CC's injected: _____

Technologist Signature: _____ Date: _____

Patient Authorization, Responsibility and Consent Form

Patient Name: _____Patient Account Number: _____

I, the undersigned, in consideration of _____ (the "procedure") by Open MRI Solutions ("Center") hereby acknowledge and agree to the following terms and conditions:

Consent to Procedure: I hereby consent to and authorize the Center to perform the procedure in accordance with general and special instructions of my treating physician or the physician supervising the procedure. I also acknowledge that my physician has fully explained to me the procedure and all risks, benefits and any alternative procedures.

Authorization/Assignment of Benefits: I hereby authorize and assign payment of any benefits due me under the terms of any insurance policy or policies that may cover the procedure performed on me _or my dependent(s) by Center directly to Center at the address designated by Center on any claim form submitted to my insurance carrier. I agree that payment to Center pursuant to this authorization/assignment by my insurance company shall discharge said insurance company of any and all obligations under the policy to the extent of such payment. I understand and agree that I am financially responsible for charges not covered by this authorization/assignment and I authorize Center to contact my employer for the purpose of determining the existence and extent of any insurance benefits. I understand that my insurance company is being billed as a courtesy and I agree that I am financially responsible to pay for any charges not covered by my insurance company. Should my account become delinquent, I agree to pay interest on the outstanding balance owed at the maximum amount permitted by law. If Center undertakes collection efforts to recover any past due amounts, I agree to pay all reasonable costs incurred, including attorney's fees.

Responsibility for Valuables: I hereby understand and acknowledge that Center is not responsible for the loss of, damage to, or theft of any of my, or and my dependent's, personal possessions, including, but not limited to, money, jewelry, clothing or other valuables, while I or my dependents are on Center's premises.

Authorization/Consent to Release Information: I hereby authorize any insurance company, prepayment organization, employer, hospital, physician, or utilization review representative to release to Center any and all information with respect to me or my dependent(s) which may have a bearing on the treatment I or my dependent(s) receive at the Center or on any benefits payable by my insurance company for the procedure performed by Center on me or my dependent(s). I agree that this authorization shall remain effective for one (1) year from the date indicated below. I hereby authorize Center to release to my insurance company or to any physician or other healthcare provider providing treatment to me or my dependent(s) all information with respect to me or my dependent(s) which may be necessary for the provision of health care services to me or my dependent(s) or regarding benefits payable to me or my dependent(s).

For Medicare Patients Only - Authorization to Release information and Payment Request: I hereby request that payment of authorized Medicare benefits be made on my behalf to Center for any services rendered by Center. I hereby authorize any holder of medical or other information about me to release to the Health Care Financing Administration or its agents, mtermed1anes or earners any information needed to determine these benefits or the benefits payable for related services. I further understand that deductibles, coinsurances and any other charges not covered by Medicare are my responsibility.

_____ _____ _____

Patient or Legal Representative Signature **Print Name and Authority (if legal representative)** **Date**

Open MRI Solutions
4130 East Van Buren St., Ste. 100
Phoenix, AZ 85008
Phone (602)244-2442 Fax (602)244-2445

PATIENT'S RIGHTS

B. An administrator shall ensure that:

1. A patient is treated with dignity, respect, and consideration;

2. A patient is not subjected to:

    1. Abuse;

    2. Neglect;

    3. Exploitation;

    4. Coercion;

    5. Manupulation;

    6. Sexual abuse;

    7. Sexual assault;

    8. Except as allowed in R9-10-1012(B), restraint or seclustion;

    9. Retaliation for submitting a complaint to the Department or another entity; or

    10. Misappropriation of personnel and private property by an outpatient treatment center's personnel member, employee, volunteer, or student; and

3. A patient or the patient's representative:

    a. Except in an emergency, either consents to or refuses treatment;

    b. May refuse or withdraw consent for treatment before treatment is initiated;

    c. Except in an emergency, is informed of alternatives to a proposed psychotropic medication or surgical procedure and associated risks and possible complications of a proposed psychotropic medication or surgical procedure;

    d. Is informed of the following:

    i. The outpatient treatment center's policy on health care directives, and

    ii. The patient complaint process;

    e. Consents to photographs of the patient before a patient is photographed, except that a patient may be photographed when admitted to an outpatient treatment center for identification and administrative purposes; and

f. Except as otherwise permitted by law, provides wirtten consent to the release of information in the patient's:.

i. Medical record, or

ii. Financial records.

C. A patient has the following rights:

1. Not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disbility, marital status, or diagnosis;

2. To receive treatment that supports and respects the patients' individuality, choices, strengths, and abilities;

3. To receive privacy in treatment and care for personal needs;

4. To review, upon written request, the patient's own medical record according to A.R.S.§§ 12-2293, 12-2294, and 12-2294.01;

5. To receive a referral to another health care institution if the outpatient treatment center is not authorized or not able to provide physical health services or behavioral health services needed by the patient;

6. To participate or have the patient's representative participate in the development of, or decisions concerning, treatment;

7. To participate or refuse to participate in research or experimental treatment; and

8. To recceive assistance from a family member, the patient's representative, or other individual in understanding, protecting, or excercising the patient's rights.

To file a complaint or grievance you may contact:

AZ Department of Health
150 N. 18th Ave., Suite 450 Phoenix, AZ 85007
Phone: 602-364-3030 Fax: (602) 542-0883

NOTE: ADHS is open Monday through Friday from 8 a.m. to 5 p.m., except state holidays.

Patient Signature:_____ **Date:**_____

Authorization for Release of Patient Medical Information

Patient Name: _____ Date of Birth: _____
Patient Address: _____ Soc. Sec. No: _____
_____
_____

Type of Exam: _____ Date of Exam: _____

I hereby request and authorize _____("Provider") to release and send the information specified to:

Open MRI Solutions, LLC
4130 E. Van Buren St., Ste 100
Phoenix, Arizona 85008

I understand that the medical information described below contains information relating to my diagnosis and treatment and do hereby consent to the release of such information. I hereby give my specific consent to release information relating to the diagnosis or treatment of drug or alcohol abuse, mental health, testing for or infection with human immunodeficiency virus (HIV), or sickle cell anemia.

Information to be released:

Entire Medical Record
MRI/CT/X-Ray/ Mammography Films (circle one)
MRI/CT/X-Ray/ Mammography Report (circle one)
Other: _____

This release and authorization does not authorize the release of any information other than that information specifically described above.

I hereby certify that I am the [Patient / Legal Guardian or Representative of the Patient] (circle one) and this request has been made freely, voluntarily and without coercion and that the informationgiven above is accurate to the best of my knowledge. I understand that this authorization is valid for one hundred and eighty (180) days from the date I sign it. I further understand that I may revoke this authorization at any time by providing written notice to the provider, unless the provider has already released the information.

Patient or Legal Representative Signature	Print Name and Authority (if legal representative)	Date

Witness or Interpreter Signature	Print Name	Date

PATIENT ACKNOWLEDGMENT TO RECEIVE PAPER COPY OF NOTICE OF PRIVACY PRACTICES

I, _____, understand that under HIPPA regulations, I have the right to request and receive a paper copy of the Notice of Privacy practices.

- □ Even if I have agreed to accept a paper copy, I am still entitled to receive the Notice of Privacy Practices electronically (E-Mail).
- □ I understand I am entitled to receive a paper copy and have chosen not to take it.
- □ If signature not obtained, please explain why:

_____

_____

_____

_____
Signature of Patient

_____
Date Signed

_____
Name of Witness

_____
Date Witnessed

AFTER PATIENT HAS RECEIVED THE NOTICE OF PRIVACY PRACTICES, PLACE THIS DOCUMENT IN PATIENT'S FILE

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 was published and became effective on April 14, 2003. If you have any questions about this notice, please contact:

Miguel Bonillas (602) 602-2442

OUR OBLIGATIONS:

We are required by law to:

- Maintain the privacy of Protected Health Information, hereafter referred to as "Health Information".
- Give you this notice of our legal duties and privacy practices regarding health information about you..
- Follow the terms of our notice that are currently in effect.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION:

Except for the following purposes, we will use and disclose Health Information only with your written permission; you may revoke such permission at any time by writing to our Privacy Officer. You may also request restricted disclosure of your health information. (See: Right to Request Restriction" below).

Treatment. We may use and disclose Health Information for you treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in you medical care and need the information to provide you with medical care.

Payment. We may use and disclose Health Information for day-to-day business activity. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use sign-in sheets and call you by name in the waiting areas.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you and remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives of health-related benefits and services that may be of interest of you.

Individuals Involved In Your Care or Payment of Your Care. When appropriate, we may share Health Information with a person who is involved in you medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one diagnostic procedure to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

SPECIAL SITUATIONS:

As Required by Law. We will disclose Health Information when required to do so by federal, state or local law.

To Avert a Serious Threat to Health Safety. We may use and when necessary to prevent a serious threat to your health and safety or the health and safety of another person. Disclosures however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services, if the information is necessary for such functions or services. For example, we may use a third party to perform transcription services on our behalf that third party would be our business associate. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as agreed upon.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We may also release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may disclose Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to: prevent or control disease, injury or disability; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products that they may be using; notify the appropriate government authority if believe a patient has been a victim of abuse, neglect or domestic violence. We will make these disclosures if you agree to them when required or authorized by law.

Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities required or authorized by law. For example, oversight activities may include audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs and compliance with civil rights.

Lawsuits and Disputes. If you are involved in a law suit or dispute, we may disclose Health Information in response to a court or administrative order. We may also disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to inform you about the request or to obtain an order protecting the information request.

Law Enforcement . We may disclose Health Information to a law enforcement or official if the information is (1) in response to a court order, subpoena, warrant, summons or simile process. (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person: (3) about the victim of a crime even if under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; on our premises. We may also disclose Health Information in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

National Security and Intelligence Activities. We may disclose Health Information to authorized federal officials related to national security activities authorized by law.

Protected Services for the President and Others. We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state, or to conduct special investigations.

Inmates or individuals in Custody. If you are an inmate of a correctional institution or under the custody of law enforcement official, we may release Health Information to the correctional institution or law enforcement official (1) to provide you with health care; or (2) to protect your health and safety or the health and safety of others.

YOUR RIGHTS:

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have the right to Inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes.

Right to Amend. If you feel that Health Information we possess id incorrect or incomplete, you may ask us to amend information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to the Clinic Manager.

Right to an Accounting Disclosure. . You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosure, you must make your request, in writing, to the Clinic Manager.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to individuals involved in your care, such as, a family member or friend. For example, you could ask that we not share information about a particular diagnostic test result or treatment with your spouse. To request a restriction, you must make your request, in writing, to the Clinic Manager. We are not required to agree to your request. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Request Confidential Communications. You have the right to request that we communicate you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communications, you must make your request, in writing, to the Clinic Manager. Your request must specify how or where you which to be contacted. We will accommodate reasonable request.

Right to a Paper Copy. You have the right to a paper copy of this notice. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, please ask our reception staff.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any Health Information we receive in the future. We will post a copy of our current notice at our office. This notice will contain the effective date on the first page.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. All complaints must be made in writing. You will not be penalized for filing a complaint. To file a complaint with our office, contact our Privacy Officer at:

PLEASE CALL 602-244-2442

OPEN MRI SOLUTIONS