OPEN AIR MRI OF LAKE CHARLES

NAME_____ **DOCTOR**_____ **CHART**_____

ADDRESS_____ **CITY**_____ **STATE** _____ **ZIP** _____

PHONE_____ **EXAMS**_____

DOB_____ **FEMALE MALE MARITAL STATUS** _____ **WEIGHT**_____ **INSURANCE** _____

GUARANTOR/INSURED INFORMATION

I hereby authorize Open Air MRI of Lake Charles to release and/or receive any and all information: (1) information requested by my insurance company or workman's compensation carrier (2) information to any hospital or physician I may be referred to and/or (3) information from hospital or physician who has previously rendered me treatment. I understand that I am ultimately responsible for payment of any and all charges and if this assignment of claim is rejected, modified, or not paid within a reasonable time after it has been filed, it may be my responsibility to pay any unpaid charges in full. I hereby authorize payment medical benefits to Open Air MRI of Lake Charles.

NAME_____ **DOB**_____ **RELATIONSHIP TO PATIENT**_____

POLICY HOLDER EMPLOYER _____ **SIGNATURE OF PATIENT**_____

Please describe your pain, injury, or discomfort in detail _____

How long have you been experiencing these symptoms _____

Previous MRI of CAT Scan that pertains to today's study? YES NO If yes, where _____

Do you have decreased renal function or undergoing renal dialysis? YES NO If yes, GFR if known _____

If on renal dialysis, when is your next dialysis appointment? _____

PLEASE ANSWER QUESTIONS ABOUT YOUR MEDICAL HISTORY

PACEMAKER OR DIFIBRILLATOR YES NO **SICKLE CELL ANEMIA YES NO** **METAL IN EYES YES NO**

EAR IMPLANTS YES NO **BLOOD DISORDER YES NO** **BULLETS OR SHRAPNEL YES NO**

HEARING AIDS YES NO **LIVER DISEASE YES NO** **DRUG INFUSION PUMP YES NO**

HEART VALVES YES NO **PREGNANT YES NO** **ANEURYSM CLIPS YES NO**

SPINAL CORD STIMULATOR YES NO **BREASTFEEDING YES NO** **STENTS/FILTER/COILS YES NO**

PROSTHESIS (EYE, PENILE, ETC) YES NO **IUD/DIAPHRAM YES NO** **DATE INSERTED** _____

HISTORY OF CANCER YES NO PLEASE LIST_____

SURGICAL METAL YES NO PLEASE LIST _____

PRIOR SURGERIES (PLEASE LIST) 1 _____ **2** _____ **3**_____

PLEASE CIRCLE YES OR NO TO QUESTIONS

Is the MRI you are having today, due to

A work related accident? YES NO

A motor vehicle accident? YES NO

WARNING: CERTAIN IMPLANTS DEVICES, OR OBJECTS MAY BE HAZARDOUS TO YOU AND/OR MAY INTERFER WITH the MRI procedure. DO NOT ENTER MRI system room or MR environment unless accompanied by MRI Technologist. If you have any question or concern regarding an implant, device, or object, consult the MRI Technologist BEFORE entering the room. The MR system magnet is ALWAYS on.

OPEN AIR MRI OF LAKE CHARLES

If yes to MVA, were you hospitalized prior to treatment related to this injury? YES NO

Are you currently enrolled in a Hospice Facility? YES NO

If yes, is today's MRI related to the Hospice treatment? YES NO

If yes, please list the name, address, and phone number of Hospice Provider

_____

Are you residing in a Skilled Nursing Facility? YES NO

If yes, please list the name, address, and phone number of the Skilled Nursing Facility

_____

WARNING: CERTAIN IMPLANTS DEVICES, OR OBJECTS MAY BE HAZARDOUS TO YOU AND/OR MAY INTERFER WITH the MRI procedure. DO NOT ENTER MRI system room or MR environment unless accompanied by MRI Technologist. If you have any question or concern regarding an implant, device, or object, consult the MRI Technologist BEFORE entering the room. The MR system magnet is ALWAYS on.

YOUR RIGHTS AS A PATIENT

Although your health record is the physical property of this office, the information belongs to you. You have the right to:

- *Inspect and obtain a copy of your health record* – Your health record contains medical records, billing records, and other records that your physician and staff use for making decisions about you. There are some records that, under Federal law, may ***not*** be inspected or copied by you. Please contact our Privacy Officer for more information.

- *Request a restriction on certain uses and disclosures of your information* – 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 or 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. 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 requested restriction if your physician believes it is in your best interest to permit use and disclosure of your protected health information. You may request a restriction form by contacting our Privacy Officer.

- *Obtain a paper copy of privacy practices upon request* – Contact our Privacy Officer.

- *Request to have your physician amend your health record* - You may request amendment of your protected health information for as long as we maintain this information; however, we may deny such a request. If we deny your request, you may file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy of that rebuttal. Contact our Privacy Officer with questions about amending your medical record.

- *Obtain an accounting of disclosures of your protected health information* – This applies to any disclosure other than treatment, payment, or healthcare operations as described in the Notice of Privacy Practices, and excluding disclosure we may have made to you, for a facility directory, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003, subject to certain exceptions, restrictions, and limitations.

- *Request confidential communications of your health information by alternative means or at alternative locations* – We will accommodate reasonable requests and will not question your request. We may, however, request payment for accommodating this request.

- *Revoke your authorization to use or disclose health information except to the extent that action has already been taken.*

This office has verbally explained my rights as a patient. I hereby acknowledge my full and complete understanding of these rights.

_____ _____

Patient's Signature Date