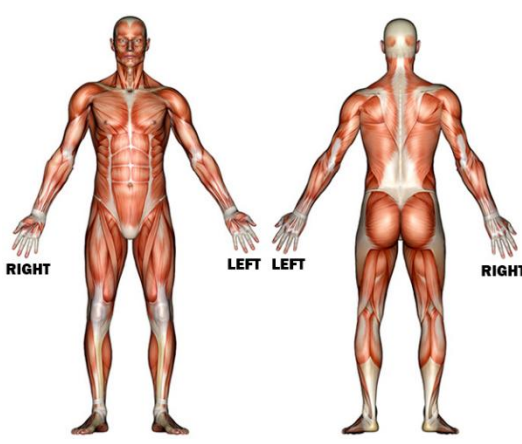


# MRI SCREENING FORM

TO OUR PATIENTS AND ACCOMPANYING FAMILY MEMBERS....

The MRI contains a very strong magnet. Before entering, we must know if there is any metal in your body. Some metal objects can interfere with your scan or be Dangerous, so PLEASE answer the following questions carefully. **FOR ANY ELECTRONIC/MECHANICAL INTERNALLY IMPLANTED DEVICE, YOU MUST PROSENT AN ID CARD FOR THE DEVICE.**

<b>What is your current weight?</b> (required for MRI Safety protocols)																					
Please list any surgeries you have had:		Please list any allergies you have?																			
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Do you have an implanted Pacemaker, Wires, or Defibrillator	The following items may become damaged or cause injury to others in a strong magnetic field. <b>THEY MUST NOT BE TAKEN INTO THE SCAN ROOM.</b> Please check off any of these items you may have with you today.																		
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you ever been a machinist, welder, or metal worker?																			
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you ever been hit in the face or eye with a piece of metal (including slivers, bullet or BBs)?																			
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you ever had a piece of metal removed from your eye?																			
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Are you pregnant, possibly pregnant, or breast feeding?																			
<b>DO YOU HAVE ANY OF THESE ITEMS IN YOUR BODY?</b>			<table border="1" style="width:100%; border-collapse: collapse;"> <tr><td><input type="checkbox"/> Hearing Aid</td><td><input type="checkbox"/> Purse/Pocketbook</td></tr> <tr><td><input type="checkbox"/> Glasses</td><td><input type="checkbox"/> Pens/pencils</td></tr> <tr><td><input type="checkbox"/> Watch</td><td><input type="checkbox"/> Keys</td></tr> <tr><td><input type="checkbox"/> Safety Pins</td><td><input type="checkbox"/> Coins</td></tr> <tr><td><input type="checkbox"/> Hairpins/Barrettes</td><td><input type="checkbox"/> Pocketknife</td></tr> <tr><td><input type="checkbox"/> Wigs/hairpieces</td><td><input type="checkbox"/> Credit or bank cards</td></tr> <tr><td><input type="checkbox"/> Jewelry</td><td><input type="checkbox"/> Belt buckle</td></tr> <tr><td><input type="checkbox"/> Wallet/money clip</td><td><input type="checkbox"/> Bra/girdle</td></tr> <tr><td><input type="checkbox"/> Metal zippers/buttons</td><td><input type="checkbox"/> Suspenders</td></tr> </table>	<input type="checkbox"/> Hearing Aid	<input type="checkbox"/> Purse/Pocketbook	<input type="checkbox"/> Glasses	<input type="checkbox"/> Pens/pencils	<input type="checkbox"/> Watch	<input type="checkbox"/> Keys	<input type="checkbox"/> Safety Pins	<input type="checkbox"/> Coins	<input type="checkbox"/> Hairpins/Barrettes	<input type="checkbox"/> Pocketknife	<input type="checkbox"/> Wigs/hairpieces	<input type="checkbox"/> Credit or bank cards	<input type="checkbox"/> Jewelry	<input type="checkbox"/> Belt buckle	<input type="checkbox"/> Wallet/money clip	<input type="checkbox"/> Bra/girdle	<input type="checkbox"/> Metal zippers/buttons	<input type="checkbox"/> Suspenders
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<input type="checkbox"/> Wallet/money clip	<input type="checkbox"/> Bra/girdle																				
<input type="checkbox"/> Metal zippers/buttons	<input type="checkbox"/> Suspenders																				
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Body piercing IF Yes, THEN STOP and resolve	<b>MARK THE LOCATION OF ANY METAL INSIDE YOUR BODY ON DRAWING</b>																		
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Brain aneurysm clip																			
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Ear implant – hearing aid																			
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Eye implant																			
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Electrical stimulator for nerves or bone																			
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Magnetic implant anywhere																			
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pain/Infusion pump																			
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Coil, Filter, Shunt, or Wire in blood vessel																			
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Prosthetic or Artificial limb or joint																			
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Eyelid, Lips, Eyebrow tattoo																			
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Implanted catheter or tube																			
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Artificial heart valve																			
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Penile prosthesis																			
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Stent																			
		IF Yes, THEN When was it put in: _____																			
<input type="checkbox"/> Yes	<input type="checkbox"/> No	False teeth, retainers, or magnetic braces																			
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Surgical clips, staples, wires, mesh, or stitches																			
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Diaphragm or intrauterine device																			
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Ortho devices (plates/screws/pins/rods/wires)																			

**INFORMATION CONCERNING GADOLINIUM CONTRAST MATERIAL**

As part of your examination, the radiologist may deem it advisable to give you an IV injection of a contrast agent containing gadolinium. This injection may help the physician more accurately diagnose your condition. Although gadolinium contrast agents have been used safely in millions of cases, minor reactions (principally headache or nausea) occur in about 2% of patients, whereas serious or life-threatening reactions have been reported in about one in 400,000 patients.

Yes  No Have you ever had an allergic reaction to gadolinium contrast?  Yes  No Do you have a history of asthma or emphysema?

I attest that the answers I have provided to questions on this form are correct to the best of my knowledge. I have read and understand the entire contents of this form and have had the opportunity to ask questions regarding the information on this form.

Signature (Parent or Guardian)

Date / Time

Tech Initials



MRI  
PATIENT HISTORY & CONSENT



Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

BODY PART TO BE EXAMINED: \_\_\_\_\_  
\_\_\_\_\_

CURRENT SYMPTOMS (If Any): \_\_\_\_\_  
\_\_\_\_\_

Approximate date symptoms began: \_\_\_\_\_ Duration of symptoms: \_\_\_\_\_

PLEASE LIST ANY PREVIOUS SURGERIES AND DATE PERFORMED: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you had previous exams of the area to be scanned today?  X-RAY  CT  MRI  US

Performed at which Facility and Approximate Date: \_\_\_\_\_

I attest that the information provided is correct to the best of my knowledge. I have read and understand the contents of this form. All of my questions regarding the MRI exam that I am about to undergo, have been answered to my satisfaction.

\_\_\_\_\_  
Patient Signature Today's Date Tech Initials

**TECHNOLOGIST USE ONLY**

Creatinine: \_\_\_\_\_ GRF (ml/min): \_\_\_\_\_ Contrast Order Verified: YES  NO

Contrast Used: \_\_\_\_\_ Contrast Amount: \_\_\_\_\_

Expiration Date: \_\_\_\_\_ Lot#: \_\_\_\_\_

NOTES: \_\_\_\_\_  
\_\_\_\_\_





## Conditions and Authorization for Medical Treatment – Outpatient

1. **CONSENT FOR MEDICAL PROCEDURES AND TREATMENT:** Permission is hereby granted to Aspire Hospital Outpatient Services for such medical procedures, including the taking of photographs and/or videos for treatment only, as may be deemed necessary by my physician and/or his or her designee. I further consent to treatment by authorized employees or agents who are assigned to my care. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as the results of treatments, examinations, emergency services, or hospital care.
2. **CONSENT FOR BLOOD BORNE INFECTIOUS DISEASE TESTING:** I give my consent to have testing for blood-borne infectious disease, including but not limited to Hepatitis, Acquired Immune Deficiency Syndrome (AIDS), and Human Immunodeficiency Virus (HIV). This test is required in the following situation(s): (1) if a health care worker is accidentally exposed to a patient’s blood or bodily fluids, such as through a needle stick, or (2) if a medical or surgical procedure is to be performed which could expose health care workers to the patient’s blood or bodily fluids. This disclosure is to inform you that you will be tested if any of these situations occur during your visit.
3. **NOTICE OF PRIVACY PRACTICES:** I acknowledge that I have been given the opportunity to review the Hospital’s Notice of Privacy Practices. I understand that if I have question or complaint, I may contact the hospital’s HIPAA Privacy Officer.
4. **PATIENT RIGHTS AND RESPONSIBILITIES:** I acknowledge that I have received a copy of the Patient Rights and Responsibilities and have had an opportunity to ask questions.
5. **ASSIGNMENT OF BENEFITS:** This assignment of benefits allows the Hospital and/or hospital based physicians to be paid directly by my health insurance carrier or other health benefit plan for the services the Hospital and or hospital based physicians provided to me, my minor child, or other person entitled to health care benefits for this visit. In consideration of the services to be rendered, the undersigned (as parent, guardian, spouse, guarantor, and agent or as the patient) individually promises to pay the patient’s account at the rates that are usual, customary, and reasonable for services rendered. Thus the entire account balance including those charges filed with the insurance company, remains the patient’s responsibility; I understand that there are providers that will bill me separately and that I am financially responsible to each provider for allowed charges not covered by this assignment.
6. **MEDICARE PATIENT CERTIFICATION:** I certify that the information given by me in applying for payment under Title XVIII and Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of the authorization to be used in place of the original and request payment of authorized benefits to be made on my behalf.
7. **RELEASE FROM RESPONSIBILITY FOR VALUABLES:** It is understood and agreed that the hospital does not maintain a safe for the safekeeping of money and valuables and that the hospital shall not be liable for loss or damage to any money, personal valuables, or personal property.
8. **PHYSICIAN OWNED HOSPITAL:** Aspire Hospital, LLC believes that you are entitled to make informed decisions regarding your medical care. To assist you in making those decisions, the Hospital hereby notifies you that it meets the federal definition of physician owned hospital pursuant to 42 C.F.R 489.3. As per the code of Federal Regulations you are hereby informed that a list of the Hospital’s physician owners and investors is available to you upon request from the Admitting Office.

I hereby certify and state that I have read, and that I fully completely understand the above Conditions of Admission and Authorization for Medical Treatment, and that I have signed Conditions of Admission and Authorization for Medical Treatment knowingly, freely, and voluntarily.

---

Signature of Patient / Parent / Guardian / Conservator

---

Date / Time

---

If other than Patient, Indicate Relationship

---

Signature of Witness

---

Date / Time



**AUTHORIZATION TO RELEASE/OBTAIN CONFIDENTIAL INFORMATION**

Please complete the following for your \_\_\_\_\_.

Name or description of procedure(s) being performed

If you do not have any one that you would like us to release information to please initial here: \_\_\_\_\_.

I, \_\_\_\_\_ hereby freely and  
Name of Patient Date of birth

voluntarily authorize Aspire Hospital, LLC to release/obtain the following to/from:

\_\_\_\_\_  
Name of Person/Facility

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, Zip Code

\_\_\_\_\_  
Phone number

My medical records may include information regarding diagnosis and treatment of DRUG, ALCOHOL, ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS), (HIV Serology) or PSYCHIATRIC DISORDERS. I understand that such information is confidential and is protected by federal law. Those receiving this information will be advised that the federal regulation (42 CFR Part 2) prohibit their making any further disclosure without written consent, or as otherwise permitted by such regulations. This information to be released includes but is not limited to:

Radiology Reports/Images       Other \_\_\_\_\_

Date of Procedure/Hospitalization: \_\_\_\_\_

I understand that I have the right to inspect and copy any written information disclosed and the right to revoke this consent at any time by giving written notice to Aspire Hospital, LLC. I UNDERSTAND REQUESTED COPIES WILL BE SUBJECT TO A REASONABLE FEE. I understand that I may not withdraw authorization for a disclosure that is necessary for the purpose of making them available to the hospital for services provided. This authorization will expire in 90 days from the date shown below unless another date is specified. Specification of the date, event or condition upon which consent expires:      Date & Time \_\_\_\_\_

**Patient/Resident MUST sign release regardless of age if alcohol and/or drug treatment involved.**

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date & Time

\_\_\_\_\_  
Parent, Guardian, or Representative Signature

\_\_\_\_\_  
Date & Time

\_\_\_\_\_  
Aspire Representative Signature

\_\_\_\_\_  
Date & Time



# Estimated Patient Financial Responsibility

Name of Patient:	Patient Account Number:	DOS:
Estimated Balance Due:	Amount Owed Today:	

I acknowledge that, for this procedure, I am the patient named and/or guarantor (i.e. financially responsible for the patient named).

As such, I agree to the following: **(Please read and initial boxes)**

- I agree to pay \$\_\_\_\_\_ today.  Please set me up on a payment plan after insurance has been billed.
- I agree to pay my share of the balance upon receipt of bill.
- I understand this is an **estimated amount for this procedure based on the verification of my insurance benefits**. Any additional balance owed after this payment will be billed directly to me.
- I understand I will receive an additional bill from ***Bryan Radiology Associates*** for the interpretation of my procedure.

By my signature below, I acknowledge that I have read and agreed to the above Payment Agreement. I understand that this is a courtesy being extended by the hospital.

Signature of Patient or Guarantor: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Signature of Witness: \_\_\_\_\_ Date: \_\_\_\_\_

## MEDICARE QUESTIONNAIRE

*Circle correct response*

Are you receiving black lung benefits?	Yes	No
Are services to be paid by a government research program?	Yes	No
Has the Dept. of Veteran's Affairs authorized and agreed to pay for your care at this facility?	Yes	No
Was illness/injury due to work related accident/condition?	Yes	No
Are you entitled to Medicare based on end stage renal disease?	Yes	No
Are you entitled to Medicare based on age or disability?	Age	Disability
Are you currently employed or retired?	Employed	Retired
Do you have a group health plan coverage based on your own or your spouse's current employment?	Yes	No

Print Name	
Patient Signature	Date