



7050 NW 4th Street Suite 303
Plantation Florida 33017
Tel: 754 778 8882
Fax: 954 703 1804

Today's Date / Fecha

mm dd yy

Personal Information / Informacion Personal

First Name / Primer Nombre		Last Name / Apellido		DOB / Fecha Nacimiento mm dd yy		SSN / Numero de Seguro Social	
Address / Direccion						Apt / Apartamento	
City / Ciudad				State / Estado		Zip Code /Codigo Postal	
Home # / Numero de Casa			Work # / Numero de Trabajo			Cell # / Numero Celular	
Sex / Sexo: ☐ F ☐ M		Marital Status / Estado Civil				☐ S ☐ M ☐ W ☐ Sep ☐ D	
Emergency Contact / Contacto de Emergencia			Telephone # / # Telefono			Email Address / Correo Electronico	
Primary Doctor / Medico Primario				Telephone # / Numero de Telefono			
Referring Physician / Medico Referente				Telephone # / Numero de Telefono			
Employer Information / Informacion Trabajo				Telephone # / Numero de Telefono			
Primary Insurance HMO ☐ PPO ☐ MEDICARE ☐ MEDICAID ☐ W/C ☐							
Name of Insured / Nombre de Asegurado				Authorization # / Numero de Autorizacion			
ID# / Numero de Asegurado				Authorization # / Numero de Autorizacion			
Secondary Insurance HMO ☐ PPO ☐ MEDICARE ☐ MEDICAID ☐ W/C ☐							
Name of Insured / Nombre de Asegurado				Authorization # / Numero de Autorizacion			
Medical Center Policies							
A. Please alert our office of any insurance or address changes. B. If you are on HMO or on an insurance company that requires authorization for your test, please make sure the authorization has been received. C. It is your responsibility to know if your insurance has specific rules or regulations, such as the need for referrals from a physician, pre-certification, and limits on outpatient charges. You should be knowledgeable of any deductibles, copayments, and/or coinsurance the responsibility for payment of fees for services is the direct responsibility of the patient. D. Your health benefit plan is an arrangement between you, the enrollee, and the insurance company, HMO, or your employer. Your health benefit plan determines your coverage, requirements, and establishes the limit on your coverage for medical services. Based on what they determine is medically necessary. However, we will do our best to assist you with understanding your proposed treatment and an answering questions related to your insurance. E. All results will be sent to your referring physician within 48-72 hours. F. Co-payments and deductibles are due at the time of service. Patients with imput or comments, please feel free to write to us at 7050 NW 4th Street, Suite 303, Plantation FL. 33017							



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Your Rights

Right to inspect or copy your PHI: Under federal law, however, you may not inspect or copy information, compiled in reasonable anticipation of, or in use in, a civil, criminal, or administrative action, or proceeding, and protected health information. that is subject to law that prohibits access.

Right to request restriction of your PHI: You may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment, or 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 the notice of Privacy Practices. Your request must be in writing, and must state the specific restrictions requested and to whom you want the restrictions to apply. The facility is not required to agree to a restriction that you may request. If the Medical Director or his appointees believe it is in your best interest to permit use and disclosure of your protected health information, your PHI will not be restricted.

Right to alternative communications: You have the right to request to receive confidential communications from us by alternate means or add the alternative location.

Right to obtain a paper copy: Upon request, even if you have agreed to accept this notice alternatively, i. e., electronically.

Right to amend your PHI: The facility has the right to deny your amendment. 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 a copy of any such rebuttal.

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

You may complain to us or to the Secretary of the Department 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.

This notice was published and becomes effective on / before April 14, 2004.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our duties and privacy practices with respects to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Signature below is only acknowledgement that you received this Notice of Privacy Practices.

Print Name

Signature

Date

MAGNETIC RESONANCE (MR) PROCEDURE SCREENING FORM FOR PATIENTS

Date ____/____/____

Patient Number _____

Name _____
Last name First name Middle Initial

Age _____

Height _____

Weight _____

Date of Birth ____/____/____

Male ☐ Female ☐

Body Part to be Examined _____

month day year

Address _____

Telephone (home) (____) ____ - ____

City _____

Telephone (work) (____) ____ - ____

State _____ Zip Code _____

Reason for MRI and/or Symptoms _____

Referring Physician _____

Telephone (____) ____ - ____

1. Have you had prior surgery or an operation (e.g., arthroscopy, endoscopy, etc.) of any kind? ☐ No ☐ Yes

If yes, please indicate the date and type of surgery:

Date ____/____/____ Type of surgery _____

Date ____/____/____ Type of surgery _____

2. Have you had a prior diagnostic imaging study or examination (MRI, CT, Ultrasound, X-ray, etc.)? ☐ No ☐ Yes

If yes, please list:

Body part

Date

Facility

MRI _____/____/____ _____

CT/CAT Scan _____/____/____ _____

X-Ray _____/____/____ _____

Ultrasound _____/____/____ _____

Nuclear Medicine _____/____/____ _____

Other _____/____/____ _____

3. Have you experienced any problem related to a previous MRI examination or MR procedure? ☐ No ☐ Yes

If yes, please describe: _____

4. Have you had an injury to the eye involving a metallic object or fragment (e.g., metallic slivers, shavings, foreign body, etc.)? ☐ No ☐ Yes

If yes, please describe: _____

5. Have you ever been injured by a metallic object or foreign body (e.g., BB, bullet, shrapnel, etc.)? ☐ No ☐ Yes

If yes, please describe: _____

6. Are you currently taking or have you recently taken any medication or drug? ☐ No ☐ Yes

If yes, please list: _____

7. Are you allergic to any medication? ☐ No ☐ Yes

If yes, please list: _____

8. Do you have a history of asthma, allergic reaction, respiratory disease, or reaction to a contrast medium or dye used for an MRI, CT, or X-ray examination? ☐ No ☐ Yes

9. Do you have anemia or any disease(s) that affects your blood, a history of renal (kidney) disease, renal (kidney) failure, renal (kidney) transplant, high blood pressure (hypertension), liver (hepatic) disease, a history of diabetes, or seizures? ☐ No ☐ Yes

If yes, please describe: _____

For female patients:

10. Date of last menstrual period: ____/____/____

Post menopausal?

☐ No ☐ Yes

11. Are you pregnant or experiencing a late menstrual period? ☐ No ☐ Yes

12. Are you taking oral contraceptives or receiving hormonal treatment? ☐ No ☐ Yes

13. Are you taking any type of fertility medication or having fertility treatments? ☐ No ☐ Yes

If yes, please describe: _____

14. Are you currently breastfeeding? ☐ No ☐ Yes

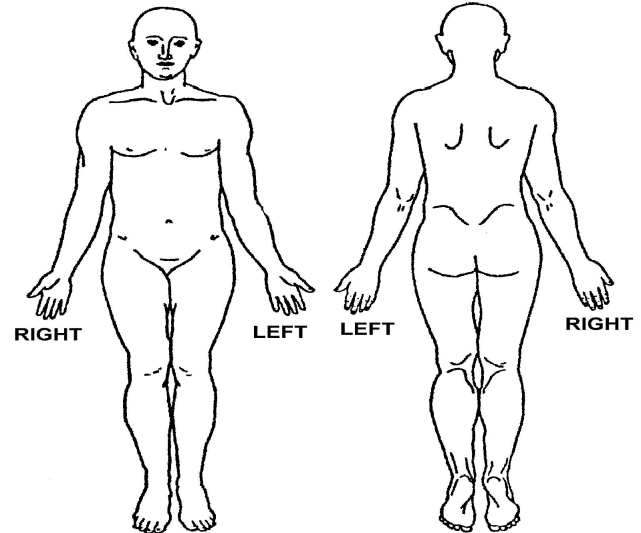


WARNING: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure (i.e., MRI, MR angiography, functional MRI, MR spectroscopy). Do not enter the MR system room or MR environment if you have any question or concern regarding an implant, device, or object. Consult the MRI Technologist or Radiologist **BEFORE** entering the MR system room. The MR system magnet is **ALWAYS** on.

Please indicate if you have any of the following:

- | | | |
|--|-----------------------------|--|
| ☐ Yes | ☐ No | Aneurysm clip(s) |
| ☐ Yes | ☐ No | Cardiac pacemaker |
| ☐ Yes | ☐ No | Implanted cardioverter defibrillator (ICD) |
| ☐ 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 catheter |
| ☐ 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 (hip, knee, etc.) |
| ☐ Yes | ☐ No | Bone/joint pin, screw, nail, wire, plate, etc. |
| ☐ Yes | ☐ No | IUD, diaphragm, or pessary |
| ☐ Yes | ☐ No | Are you here for an MRI examination? |
| ☐ Yes | ☐ No | Dentures or partial plates |
| ☐ Yes | ☐ No | Tattoo or permanent makeup |
| ☐ Yes | ☐ No | Body piercing jewelry |
| ☐ Yes | ☐ No | Hearing aid |
| <i>(Remove before entering MR system room)</i> | | |
| ☐ Yes | ☐ No | Other implant _____ |
| ☐ Yes | ☐ No | Breathing problem or motion disorder |

Please mark on the figure(s) below
the location of any implant or metal
inside of or on your body.



IMPORTANT INSTRUCTIONS

Before entering the MR environment or MR system room, you must remove all metallic objects including hearing aids, dentures, partial plates, keys, beeper, cell phone, eyeglasses, hair pins, barrettes, jewelry, body piercing jewelry, watch, safety pins, paperclips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clipper, tools, clothing with metal fasteners, & clothing with metallic threads.

Please consult the MRI Technologist or Radiologist if you have any question or concern **BEFORE** you enter the MR system room.

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.

I attest that the above information is correct to the best of my knowledge. I read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form and regarding the MR procedure that I am about to undergo.

Signature of Person Completing Form: _____
Signature

Date ____/____/____

Form Completed By: ☐ Patient ☐ Relative ☐ Nurse _____
Print name Relationship to patient

Form Information Reviewed By: _____
Print name Signature

☐ MRI Technologist ☐ Nurse ☐ Radiologist ☐ Other _____