"High Resolution Imaging on a High FieldStrength, OPEN Bore Magnet, ……..All of the time."

"Because our patients deserve the best."

Name _____ **M / F** **Age** _____ **Weight** _____ **Date of Birth** _____/_____/_____
Last name First name Middle initial sex Month Day Year

Marital Status: M / S / D / W **Race:** White / Black or African American / Asian / American Indian / Native Hawaiian / Other: _____

Ethnicity: Hispanic or Latino / not Hispanic or Latino **Language:** English / Spanish / Other:_____ **Dominant Hand:** Lt Rt

Address _____ **Telephone (home)** (_____) _____ - _____

City _____ **Telephone (cell)** (_____) _____ - _____

State _____ **Zip Code**_____ **Social Security #:** _____ - ____ - _____ **Employer** _____

Body Part to be Scanned_____ **Referring Physician** _____

Reason for MRI and/or Symptoms _____

Who is the insurance subscriber (if not patient) ?

_____ _____ **Date of Birth** ___/___/___ **Social Security #:** _____ - ____ - _____
Last name First name Mth Day Year

If patient is a minor, who is the responsible party? _____ _____
Last name First name

Address (if different) _____ **Telephone (home) (_____)** _____ - _____

City _____**State**_____**Zip Code**_____ **Telephone (work) (_____)** _____ - _____

WARNING: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure. **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 **BEFORE** entering the MR system room. **The MR system magnet is ALWAYS on. **IF YOU HAVE A PACEMAKER, BRAIN ANEURYSM CLIP, CARDIAC DEFIBRILATOR, OR SPINAL STIMULATOR YOU CAN NOT HAVE AN MRI!!**

1. Do you understand the warning written above. No [ ] Yes [ ]

2. Have you had an injury to the eye involving a metallic object or fragment (e.g., metallic slivers, shavings, foreign body, etc.)? No [ ] Yes [ ]
(PLEASE RESPOND YES, EVEN IF YOU HAVE HAD THE METAL REMOVED)

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

4. Have you had prior surgery or an operation of any kind? No [ ] Yes [ ]
If yes, please indicate the type of surgery:
Type of surgery _____
Type of surgery _____

5. Have you had a prior MRI? No [ ] Yes [ ]

6. Have you experienced any problem related to a previous MRI examination or MR procedure? No [ ] Yes [ ]
If yes, please describe: _____

For female patients:
7. Date of last menstrual period: _____ / _____ /_____

Do you have any of the following:

Yes	No	Aneurysm clip(s)*** ***IF YOU ANSWER YES YOU CAN NOT HAVE AN MRI***
Yes	No	Cardiac pacemaker)*** ***IF YOU ANSWER YES YOU CAN NOT HAVE AN MRI***
Yes	No	Implanted cardioverter defibrillator (ICD))*** ***IF YOU ANSWER YES YOU CAN NOT HAVE AN MRI***
Yes	No	Electronic implant or device
Yes	No	Insulin Pump/ Implanted drug infusion device
Yes	No	Neuro/ Spinal cord stimulator system)*** ***IF YOU ANSWER YES YOU CAN NOT HAVE AN MRI***
Yes	No	Cardiac loop recorder
Yes	No	Internal electrodes or wires
Yes	No	Bone growth/bone fusion stimulator
Yes	No	Cochlear, otologic, or other ear implant
Yes	No	Stent, Filter, or Coil
Yes	No	Shunt (spinal or intraventricular)
Yes	No	Any type of prosthesis (eye, penile, etc.)
Yes	No	Artificial or prosthetic limb
Yes	No	Electronic monitoring device(Ankle bracelet)
Yes	No	IUD, diaphragm, or pessary
Yes	No	Eye enlarging contacts
Yes	No	Joint replacement (hip, knee, etc.)
Yes	No	Bone/joint pin, screw, nail, wire, plate, etc.
Yes	No	Metal fabric clothes (Tommy Copper-LULULlemon)
Yes	No	Tattoo or permanent makeup ***(In last 6 weeks)***
Yes	No	Concealed weapon (Must be left in vehicle)
Yes	No	Other implant _____
Yes	No	Hearing aid ***(Remove before entering MR room)***
Yes	No	Claustrophobia

******IMPORTANT INFORMATION*****

Before entering the MR environment or MR system room, you , depending on what exam you are scheduled for, remove metallic objects including 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 if you have any question or concern BEFORE you enter the MR system room. You will be required to wear earplugs or headphones 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. Furthermore, I give consent to the staff of **THE MRI CENTER @OSTC** to perform this MR procedure on me.

Signature of Person Completing Form: _____ Date _____/_____/_____

Signature

PLEASE READ AND INITIAL

____ **RELEASE OF INFORMATION** ***(This allows us to send a report of to your Doctor and/or insurance company)***

I authorize ***THE MRI CENTER @OSTC*** to release any medical information requested by other physicians or representatives of local, state, or federal agencies; insurance companies; or other organizations or entities as may be required by said representatives for treatment or payment of claims arising out of this procedure as are due ***THE MRI CENTER @OSTC.***

____ **FINANCIAL RESPONSIBILITY**

I understand that regardless of any assigned insurance benefits, I am responsible for the total charges for services rendered.

____ **INSURANCE ASSIGNMENT** ***(This allows and directs your insurance company to pay us directly)***

In consideration of services received, I hereby assign and transfer to ***THE MRI CENTER @OSTC*** any benefits payable to or for my benefit under any medical insurance or any other insurance coverage.

____ **RADIOLOGY BILL**

I understand that I will receive a separate bill for the reading of the MRI from Radiology Associates of Wichita Falls.

____ **NOTICE OF PRIVACY PRACTICES**

I acknowledge that the Notice of Privacy Practices of Orthopaedic Associates/MRI Center @ OSTC was made available for me to read,