**CRYSTAL RIVER MRI**

Patient Name: ______________________________ PT #: ______________

Home Phone: ( _______ ) ________ - ____________ Alternate Phone: ( _______ ) ________ - __________ EXT: ______________

Address: ______________________________ Apt # : ______________

City: ______________________________ State: ____________ Zip: ______________

Social Security #: ____________________ **Date of Birth:** ______________ **Age:** ________ **Sex** ________

Drivers License: ________________ Marital Status: S / M / W / D Spouse Name: ________________

Emergency Contact: ______________________________ Phone:( _______ ) ________ - ________

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**PATIENT HISTORY – ALL PATIENTS**

Today's Date: ____________________ What is your current weight: ____________________

Please describe the symptoms you are experiencing: ______________________________

1. Do you have any of the following:

!**Cardiac Pacemaker** !Cochlear(EAR) Implantor Prosthesis !**HearingAids** !**Neurostimulators**
!Infusion Pumps !Dentures/Partials/Braces/Retainer !**Intracranial AneurysmClips** !Patch (nicotine,pain, etc)
!Shrapnel/Bullets !Orbital Implantor Prosthesis !Prosthetic HeartValve !Metal FragmentsinEye
!Intrauterine Device !Inferior VenaCava(IVC)Filter/Umbrella !Penile Implant

OR- !**I attestthat I DO NOT have any of the above**

2. Have you ever had surgery? !No ! Yes,list: ______________________________

______________________________

3. Are you taking any medications? !No ! Yes,list: ______________________________

______________________________

4. Are you allergicto any medications? !No !Yes, list: ______________________________

5. For **WomenONLY**,is therea possibilityofpregnancy? !No !Yes !Not Applicable

6. Is this a resultof an injury?: !No !Yes: Date of Injury: ____________________

Was the injurya resultof: !Auto Accident !Work RelatedInjury !Slip and Fall !Other: ______________
State Vehicle Registered: _______

Briefly describe what happened? ______________________________

I agree that all the information on this form is true and accurate to the best of my knowledge.

| ______________________ | ______________________ | __________ |
|---|---|---|
| Signature | Printed Name | Date |

# MRI ASSOCIATES OF CRYSTAL RIVER, LLC.
# AUTHORIZATION AND AGREEMENTS FOR
# MRI / MRA / X-RAY / SERVICES

Patient Name: ______________________________________________

The undersigned hereby makes the following Acknowledgment and Agreement regarding the MRI/MRA/X-Ray services to be provided to the patient whose name appears above.

## CONSENT FOR MRI / MRA / X-RAY
## TECHNICAL/PROFESSIONAL SERVICES

I understand that services rendered are necessary for the patient by the above company and its physicians. I hereby consent to and authorize the administration of the MRI/MRA/X-Ray Study that may be considered advisable or necessary in the judgment of the referring physician. I authorize any medical records may be obtained by the above companies.

## ENHANCEMENT CONSENT

Your doctor may order an image enhancement agent to be used for your MRI/MRA study. This agent makes the details of the MRI/MRA study clearer and does not mean your condition is more serious or that there is anything additionally wrong with you. We are asking your consent to use the enhancement only if your doctor has requested this use, or if it is deemed medically necessary.

## AGREEMENT TO PAY FOR SERVICES

For and in consideration of the services provided to the patient, I promise to pay the above company for all charges and services rendered to or in behalf of the patient. The above company may secure any credit information that may be necessary. I also understand that I may be insured through a PPO/HMO plan and that it is my responsibility to obtain the proper and necessary referrals from my primary care physician before services are rendered. The above company shall make all reasonable efforts to assure that the insured is covered by the plan, but ultimately I understand that it is my responsibility.

## DIRECT PAYMENT AUTHORIZATION

By way of original or a copy hereof, the undersigned patient hereby directs the applicable personal injury protection or medical payments insurance carrier to make payment directly to the above companies. If payment is made out to the above company they have the authorization to endorse the payment with the patient's signature along with its own.

## RELEASE OF INFORMATION

I hereby authorize the above company to release any information in the course of my treatment to my insurance company or any physician needing this information for treatment.

## COLLECTION OF ACCOUNT

I understand that if this account is assigned to an attorney for collection and/or suit, the above company shall be entitled to reasonable attorney's fees and cost of collection. I also understand that if any bad check is written, I am to pay only by cash, money order or credit card to redeem that check and if added cost is incurred to the above company I agree to pay for those fees.

______________________________ ______________________

Signature of Patient/Responsible Party Date

CRYSTAL RIVER

# CONSENT OF DISCLOSURE

(For the Usage and / or Disclosure of Protected Health Information)

**I hereby give consent to MRI Associates of Crystal River, LLC. D/B/A Crystal River MRI to use and disclose my protected health information (PHI) for the purposes of treatment, payment and health care operations.**

You may cancel this consent at any time. Your cancellation must be in writing, signed by you or on your behalf, and delivered to the address at the bottom of this form. This may be delivered in person by mail, but it will only be effective when we actually receive it. Your cancellation will not be effective to the extent that we or others have acted in reliance upon this consent.

You have the right to request restriction on the usage and disclosure of your protected health information for the purposes of treatment, payment or health care operations. We are not required to grant your request, however, if we do, the restriction will be obligatory to us.

Our Posted Privacy Policy provides more detailed information about the usage and disclosure of your protected health information. You have the right to review our Posted Privacy Policy before you sign this consent.

We reserve the right to amend the terms of our Posted Privacy Policy. You may obtain a copy of the current policy by calling us at (352) 437-8005.

Print Name of Patient: ____________________________________________________

Sign: __________________________________________________Date: ________________

If you are signed as the patient's representative:

Print your Name: ________________________________________________________

Relationship: ___________________________________________________________

• Crystal River MRI•6136 W Gulf to Lake Hwy •Crystal River, FL 34429 •(352) 437-8005•Fax (352) 228-4323•

CRYSTAL RIVER

## Authorization for Records Release

"

Patient Name: ____________________________________a____________ Acct #: __aaaa_________

"

Date of Birth: ___________________________ Social Security #: ____a__aaaaa_______________

"

I hereby authorize Crystal River MRI access to my medical records with respect to my medical condition or treatment. These records are being requested to assist in the continuity of my patient care at Crystal River MRI. I understand that I may revoke the authorization at any time, and in order to do so, I must send written notice to the healthcare provider(s).

"

Signature: _________________________________________________a___ Date: ___aaaa________

"
"

I hereby authorize Crystal River MRI to release or disclose my medical records to the following people:

"

_________________________a______________ """""""""" _____________________aaaaaaaa__
Name Relationship

________________________a_______________ """""""""" __________________aaaaaaa______
Name Relationship

________________________a_______________ """""""""" _________________aaaaaa___a____
Name Relationship

I understand that I may revoke the authorization at any time, and in order to do so, I must send written notice to the healthcare provider(s).

"

Signature: __________________a_________________________________ Date: __aaaa__________

**MRI • 6136 W Gulf to Lake Hwy • Crystal River, Florida 34429 • Phone (352) 437-8005 • Fax (352) 228-4323**

## CYRSTAL RIVER MRI CONSENT FOR SCAN WITH CONTRAST

Your attending physician has consulted us to do an exam that will require an injection of radiopaque contrast material, some containing iodine. Before we can proceed with the exam, please answer the following questions.

**Have you ever had any of the following:**

Asthma　　Hay Fever　　High Blood Pressure

Hives　　Heart Disease

Blood Disease　　Renal Disease/Failure

| Question | | |
|---|---|---|
| Are you sensitive to Iodine or Gadolinium?................................................. | **No** | **Yes** |
| Are you diabetic?........................................................................................ | **No** | **Yes** |
| Do you take Glucophage or Metformin medication?..................................... | **No** | **Yes** |
| Have you been diagnosed with Multiple Myeloma or Pheochromocytoma? | **No** | **Yes** |
| Do you have sickle cell anemia?.................................................................. | **No** | **Yes** |
| Have you had or are you scheduled for a Liver Transplant?......................... | **No** | **Yes** |
| Have you ever had a reaction to intravenous contrast material (dye)?.......... | **No** | **Yes** |

Please list any allergies:

______________________________________________________________

______________________________________________________________

**If you answered "YES" to any of the above questions, please alert the technologist.**

I UNDERSTAND THAT DESPITE PRECAUTIONS, THERE IS A LIMITED RISK OF COMPLICATIONS TO THIS PROCEDURE. THESE COMPLICATIONS COULD INCLUDE A REACTION TO CONTRAST MATERIAL WHICH, IN RARE CASES COULD BE FATAL. I UNDERSTAND THAT THIS TYPE OF STUDY YIELDS ANATOMIC INFORMATION THAT IS NOT OBTAINABLE BY OTHER TYPES OF EXAMINATIONS SUCH AS NUCLEAR MEDICINE TECHNIQUES OR ULTRASOUND. IN THE UNLIKELY EVENT OF A REACTION TO THE CONTRAST MATERIAL, I FURTHER GRANT MY PERMISSION TO ADMINISTER ANY MEDICATION OR PERFORM ANY ADDITIONAL PROCEDURES AS MAY BE JUDGED ADVISABLE BY THE SUPERVISING PHYSICIAN.

I ASSUME THE RISK CONNECTED WITH THIS EXAMINATION, IN VIEW OF THE POSSIBLE BENEFITS THAT MAY BE OBTAINED.

______________________________　　____________________

Patient's Signature　　Date

______________________________

Please Print Name

Technologist Use ONLY:

BUN: ____________CREAT: __________　　Date Drawn: ______________________

Contrast Medium used: _________________________ Total Units________________________

Technologist Signature ________________________________Date ____________________

# CRYSTAL RIVER MRI
## MRI OF THE BREAST PATIENT QUESTIONNAIRE

PATIENT NAME: ______________________________________________________________

PATIENT #: _________________________ DATE OF EXAM: ________________________

PLEASE ANSWER THE FOLLOWING QUESTIONS:

ARE YOU STILL MENSTRUATING (HAVING PERIODS)?:
- YES: WHAT IS THE DATE OF YOUR LAST MENSTRUAL PERIOD (FIRST DAY)? ___________________
- NO: WHEN DID YOU STOP MENSTRUATING (YEAR)? ___________

WAS THIS DUE TO:
- MENOPAUSE
- HYSTERECTOMY
- OTHER

DO YOU TAKE HORMONE REPLACEMENT THERAPY (HRT)?
- NO
- YES

IF YES, DO YOU EXPERIENCE BREAST PAIN WHILE TAKING HRT?
- YES
- NO

HAVE YOU HAD PREVIOUS SURGERY ON YOUR BREASTS?
- NO
- YES

IF YES, WHAT TYPE OF SURGERY?
- BIOPSY R/L YEAR: ____________
- MASTECTOMY R/L YEAR: ____________
- OTHER R/L YEAR: ____________

HAVE YOU HAD RADIATION THERAPY TO YOUR BREAST AREA?
- NO
- YES

IF YES, WHEN DID THE TREATMENT FINISH (MONTH/YEAR): _______________