OAKLAND MRI

MRI INTERVIEW AND CONSENT FORM

NAME: _____DOB: _____

SS#: _____ ADDRESS:_____

CITY:_____ STATE:_____ ZIP: _____

PHYSICIAN:_____HEIGHT:_____WEIGHT:_____

INSURANCE: _____MEMBER ID#_____GROUP#_____

SECONDARY INS.: _____MEMBER ID#_____GROUP#_____

CELL #:_____HOME #: _____

PRIMARY POLICY HOLDER: _____SELF _____SPOUSE _____PARENT _____ OTHER

IF DIFFERENT THAN THE PATIENTS, PLEASE COMPLETE THE FOLLOWING:

POLICY HOLDERS NAME:_____DOB_____

ADDRESS_____

EXAM: _____ CONTRAST?_____

ALLERGIES:_____

EMERGENCY CONTACT (NAME & #):_____

MEDICATION LIST:

IS YOUR MRI DUE TO: _____SLIP & FALL____WORKERS COMPENSATION____AUTOMOBILE ACCIDENT

ATTORNEY NAME AND PHONE NUMBER_____

YES	**NO**	
Y	N	ARE YOU CLAUSTROPHOBIC?
Y	N	CAN YOU LIE FLAT FOR AT LEAST 30 MINUTES?
Y	N	ALLERGIC TO IODINE OR SEAFOOD?
Y	N	TATTOO OR PERMANENT MAKEUP?

Y N PACEMAKER? _____ ANEURYSM CLIP? _____

Y N METAL IMPLANTS IN BODY? WHAT? _____

YEAR _____ MODEL # _____ SERIAL # _____

Y N OTHER IMPLANTED DEVICE? _____

Y N TRANSDERMAL PATCHES _____

Y N PREGNANT OR NURSING

Y N BODY PIERCINGS

Y N HEARING AID

Y N DENTURES OR PARTIALS

Y N GUNSHOT WOUNDS

Y N WIG

Y N JOINT OR LIMB REPLACEMENT

Y N PENILE PROSTHESIS

Y N INTERNAL CONTRACEPTIVE DEVICE

Y N HEART VALVE SURGERY

Y N SEIZURES _____

Y N CANCER _____DATE _____

Y N KNOWN OR POSSIBLE METAL IN EYES? _____ ORBITS? _____

Y N PREVIOUS SURGERY?_____

Y N HYPERTENSION? _____

Y N DIABETIC? _____ ORAL/INSULIN? _____

Y N KIDNEY ISSUES OR DIALYSIS? _____

Signature of Patient _____ Date _____

E-Mail Address _____

MRI QUESTIONNAIRE

Your doctor has scheduled you for an MRI examination that may require an injection of a contrast agent into your bloodstream. This is a non-ionic contrast material containing gadodiamide. This material has magnetic properties and therefore develops a magnetic moment when placed in a magnetic field. This material helps detect and characterize abnormalities that may not be seen without their use and is approved by the Food and Drug Administration.

Normally, contrast media is quite safe; however, any injection carries a slight risk of harm including injury to a nerve, artery or vein, infection or reaction to the material being injected. Occasionally, a patient will have mild allergic-type reactions to the gadodiamide and develop headaches or nausea.

Very rarely, a more serious or life threatening reaction will occur with the administration of gadodiamide; the physicians and staff of Oakland MRI are trained to treat these reactions.

Nursing mothers should refrain from breastfeeding for 48 hours after receiving an injection of MRI contrast.

I have read the questionnaire and contrast form. By signing this form, I acknowledge that my questions have been answered regarding the administration of contrast media, and I agree to receive the contrast media if needed.

Patient Signature **Date**

MRI Staff Signature

Payment Policy

Thank you for choosing Oakland MRI as your diagnostic imaging provider. We are committed to providing you with quality and affordable health care.

Please read the following office payment policy and feel free to ask us any questions that you may have. Once you accept this policy, kindly sign in the space provided. A copy will be provided to you upon request.

1. **Insurance.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we participate with but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
2. **Non-covered service.** Please be aware that some-and perhaps all-of the services you receive may be uncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.
3. **Proof of insurance.** All patients must complete our patient information form before testing is performed. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim. If required, obtaining the proper referral from your Primary Care Physician is your responsibility. Patients presenting to our office without a valid referral will be asked to pay in full. This payment will be held for 48 hours and will become non-refundable if the proper referral is not obtained by then.
4. **Claims submission.** We will submit you claims and assist you in any way were reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. You insurance benefit is a contract between you and your insurance company.
5. **Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.
6. **Nonpayment.** Invoices are sent out every 30 days. Your prompt payment will assist us in keeping the cost of healthcare down. If your account is over 60 days past due, you will receive a letter requesting immediate payment. A re-billing charge of $10.00 per month will accrue on all accounts over 60 days past due. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to small claims court and you and your immediate family members may be discharged from this practice.
7. **Missed appointments.** Our policy is to charge $150.00 for missed appointments not canceled within a reasonable amount of time (24 HOURS) or for an understandable reason. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping you regularly scheduled appointment.

Our fees are representative of the usual and customary charges of our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines

Signature of patient or responsible party Date

Authorization for Release of Medical Records

Last Name First Name Middle Initial Maiden Name

Birth Date Social Security Number

I hereby authorize: Oakland MRI
5119 Rochester Road, Troy, Michigan 48085

to release information in my medical records, including (unless otherwise noted in #3 below):

- Information about communicable disease and infections, as defined by statue and Michigan Department of Public Health rules (which include venereal disease (VD), tuberculosis (TB), hepatitis B, human immunodeficiency virus (HIV), acquired immunodeficiency syndrome (AIDS) and AIDS related complex (ARC).
- Alcohol and drug abuse treatment information protected under the regulations in 42 Code of Federal Regulations, Part 2
- Mental health treatment records, psychological services and social services information communications made by me to a social worker or psychologist.

I authorize such disclosure to the individuals or organizations listed blow in accordance with the conditions listed above:

1. Person(s) or Organization(s) to whom disclosure is to be made:
   Oakland MRI, 5119 Rochester Rd, Troy, Michigan 48085

2. Specify type of information to be disclosed: _____

   _____

3. Specify type of information NOT to be disclosed: _____

   _____

4. Purpose of need for such disclosure: _____

   _____

This authorization is subject to written revocation at any time except to the extent that action has already been take in reliance on the authorization. If not previously revoked, this authorization will terminate six (6) months from the date of signature.

Signature of Patient/Parent/Guardian/Authorized Representative Date

Oakland MRI
Experience The Difference

Oakland MRI
5119 Rochester Rd., Troy, MI 48085
Phone: 248.740.0777
Fax: 248.740.9777
www.oaklandmri.com

Privacy Notice

Healthcare Privacy
Each time you visit a hospital, physician or other healthcare provider a written or electronic record of you visit is made. Typically this record contains your symptoms, examination and test results, diagnosis, treatment and a plan for future care and treatment. Protecting your privacy is very important to us. All of our patients have the right to considerate and respectful care.

Privacy Practices for Protected Health Information
The provision of high-quality healthcare requires the exchange of personal, often sensitive information between an individual and a skilled practitioner. Vital to the interaction is the patient's ability to trust that he information shared will be protected and kept confidential. Yet many patients are concerned that their information is not protected.

Your Health Information Rights
Although your health record is the physical property of the healthcare practitioner in the facility that compiled it, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information
- Obtain a paper copy of the notice of information practices upon request
- Inspect and copy your health record
- Request to amend your health record
- Obtain an accounting of disclosures
- Request communication of your health information by alternative means or at alternative locations
- Revoke your authorization to use or disclose health information except to the extent action has already been taken

Consent Agreement
A "consent" allows use and disclosure of protected health information only for treatment, payment and healthcare operations.

As part of your healthcare, we originate and maintain health records describing your health history, symptoms, examination and test results, diagnosis, treatment and nay plans for future care or treatment.

This information is a basis for:

- Planning treatment
- A means of communication among the many health professionals who contribute to your care
- A source of information for applying your diagnosis and surgical information to your bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

Confidentiality
Expect that all aspects of your care will be treated confidentially. Your medical record, both written and electronic, will not be released without your written permission, unless associated with your healthcare operations. These operations include but are not limited to evaluation and review of healthcare professionals, quality reviews, assessments, improvements and training activities, licensing and credentialing activities, and certification and accreditation programs. Our office may use or disclose your healthcare information to a physician or other healthcare provider who is providing treatment to you; your healthcare information will be used and disclosed by our office to obtain payment for services rendered to you.

You have the right to:

- Take part in decisions about your care. Before agreeing to any treatment, your doctor will tell you about your plan of care in terms you can understand.
- Refuse further medical care. If you make this decision, it is important that you understand the risks and how it can affect your health. If you refuse care, you become responsible for your future health outcomes. If you and your doctor cannot agree about your care which meets ethical and professional standards, you may be asked to seek treatment elsewhere.

This notice describes how medical information about you may be disclosed and how you can get access to the information. Please review it carefully. It is the right of this office to change this policy at any time as long as the changes are in accordance with applicable law. You may receive this notice via our website or email; you are also entitled to receive this notice in written form from our office.

Acknowledgement of Privacy Notice

By signing below, I acknowledge that I have received the Oakland MRI Notice of Privacy

_____

Signature (Patient or Authorized Representative) Date

_____

Printed (Patient or Authorized Representative)

_____

Witness Date