

PATIENT INFORMATION

Date _____ Soc. Sec. # _____

Patient's Last Name _____ **First** _____ **Middle** _____

Age _____ Date of Birth ___/___/___ Sex _____ Marital Status _____

Telephone Home () _____ Cell () _____

Street _____ Apt# _____

City _____ State _____ Zip _____

Employer Name _____

Employer Address _____

Occupation _____ Work () _____

Name of Spouse, Parent or Legal Guardian _____

Telephone Number () _____

Street _____ Apt# _____

City _____ State _____ Zip _____

Date of Birth ___/___/___ SS# _____

Employer/Occupation _____

Employer _____

Address _____ Phone _____

Primary Insurance _____

Cardholder's Name _____ Cardholder's D.O.B. ___/___/___

Secondary Insurance _____

Cardholder's Name _____ Cardholder's D.O.B. ___/___/___

Emergency Contact _____ Telephone () _____

Relationship _____ Location _____

Is your visit related to employment or an auto accident? NO YES (if yes complete below)

Date of injury: _____

PATIENT MEDICAL HISTORY

Do you, the patient, have a personal history of – (please circle)

Yes No Cancer Type _____ Date _____

Yes No Kidney disease/dialysis Type _____ Date _____

Yes No High Blood Pressure

Yes No Diabetic

Yes No Seizure Describe _____ Date of last one _____

Yes No Stroke Describe _____ Date of stroke _____

List any other medical conditions _____

Have you ever had another test of the area that is being scanned today?

| | <u>Body area</u> | <u>Location/Facility</u> | <u>Date</u> |
|--------|--|--------------------------|-------------|
| Yes No | X-ray _____ | _____ | _____ |
| Yes No | MRI _____ | _____ | _____ |
| Yes No | CT _____ | _____ | _____ |
| Yes No | Nuc Med _____ | _____ | _____ |
| Yes No | Ultrasound _____ | _____ | _____ |
| Yes No | Mammogram/Thermogram _____ | _____ | _____ |
| Yes No | Echo (Cardiac MRI Patients only) _____ | _____ | _____ |

What is your main complaint or reason your doctor ordered your test today?

How long have you had this complaint/symptom? (please give an approximate timeframe for each symptom)

Are your symptoms: _____ Improving Describe _____
_____ Getting Worse Describe _____
_____ About the Same Describe _____

Yes No Did you sustain an injury to the area to be scanned? If yes, please describe _____

Yes No Do you have a limited range of motion? If yes, please describe _____

Yes No Do you have any swelling? If yes, please describe _____

Yes No Do you have any discoloration? If yes, please describe _____

Yes No Do you have any numbness/tingling? If yes, please describe _____

Yes No Do you have any weakness? If yes, please describe _____

Yes No Have you had any surgery to the area being scanned today? If yes, please describe and include an approximate date _____

Signature _____ Date _____ Witness _____

MRI INFORMED CONSENT/PAYMENT OF SERVICES

Purpose of this test:

Your physician has ordered an MRI procedure to aid in the diagnosing and treating your complaint. In some cases, a contrast agent may be injected into your vein or joint to better define the area of interest.

Methods and Side Effects:

For patients having an MRI with contrast:

Anytime an injection is given there is a possibility for complications and/or an allergic reaction.

Complications

- Pain
- Bleeding
- Bruising
- Swelling
- Infection
- Extravasations (leaking into the tissue)

Reactions

- Nausea/Vomiting
- Headache
- Hives
- Itching/Rash
- Warm Sensation
- Dizziness

- If you experience any of the conditions listed above you must tell the technologist.
- More serious reaction may occur. There have been rare instances of death after the administration of contrast.
- Should you experience any of these reactions, emergency equipment and trained personnel are available to handle these unusual situations.
- FDA recommends patients with renal disease to be screened prior to the administration of MRI contrast due to a connective tissue disorder.

For patients having an arthrogram: This procedure involves administering local anesthetic and injecting a contrast medium into the joint through a needle, and is followed by MRI imaging. There may be a slight burning sensation when the anesthetic agent is injected. This will pass quickly. During injection of the contrast medium, you may feel pressure or pain; this is normal for this procedure. Pain and soreness may last up to 24 hours after injection.

I have read and understand the above information and have had all of my questions answered regarding the procedure that I am about to undergo. I believe that I have sufficient information to consent for the procedure to be performed on minor or myself.

I also certify that the information I have reported regarding my insurance is correct. It is my responsibility to know my individual medical coverage since my coverage is personal and not between my insurance company and Thumb MRI. I understand that I am ultimately responsible for any unpaid balance if my insurance does not pay. In the case of Worker’s Comp, a “Letter of Dispute” does not guarantee payment from my insurance company or worker’s comp company. I also authorize Thumb MRI to release information about me to my insurance company and its agents. Please note that unresolved accounts after 90 days may be turned over to a credit agency for collection.

I authorize payment to be made directly to Thumb MRI Center.

Is your visit related to employment or an auto accident? NO YES

Patient Name

Responsible Party’s Signature

Date

Witness Signature

Date

MRI SAFETY SHEET

WARNING! -Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure-MRI or MR Angiography.

IMPORTANT INSTRUCTIONS – Before entering the MRI room, you must remove all metallic objects including hearing aids, wallet, keys, hair pins/accessories, credit cards, pocket knife, certain clothing with metal fasteners, etc.

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.

If you would like earplugs please ask the technologist. **THE MR SYSTEM MAGNET IS ALWAYS ON.**

Please circle if you have any of the following:

- | | | | | | |
|-----|----|--|-----|----|--|
| Yes | No | Aneurysm Clip(s) | Yes | No | Radiation Seeds or Implant |
| Yes | No | Cardiac Pacemaker | Yes | No | Bone/Joint Pin, Screw, Nail, Wire, Plate |
| Yes | No | Implanted Cardioverter Defibrillator (ICD) | Yes | No | Tissue Expander (e.g. Breast) |
| Yes | No | Electronic Implant or Device | Yes | No | Wire Mesh Implant |
| Yes | No | Magnetically-Activated Implant or Device | Yes | No | Spinal cord stimulator |
| Yes | No | Neurostimulation system | Yes | No | Shunt (spinal or intraventricular) |
| Yes | No | Any metallic fragment or foreign body | Yes | No | Joint replacement (hip, knee, etc.) |
| Yes | No | Internal Electrodes or Wires | Yes | No | Surgical Staples, Clips, or Metallic Sutures |
| Yes | No | Bone Growth/Bone Fusion Stimulator | Yes | No | Any Type of Prosthesis (Eye, Penile, etc.) |
| Yes | No | Cochlear, Otologic, or other Ear Implant | Yes | No | Medication Patch (Nicotine, (Nitroglycerine) |
| Yes | No | Insulin or other Infusion Pump | Yes | No | Artificial or Prosthetic Limb |
| Yes | No | Implanted Drug Infusion Device | Yes | No | Tattoo or Permanent Makeup |
| Yes | No | Heart Valve Prosthesis | Yes | No | Eyelid Spring or Wire |
| Yes | No | Metallic Stent, Filter, or Coil | Yes | No | Body Piercing Jewelry |
| Yes | No | Vascular Access Port and/or Catheter | Yes | No | Dentures, or Partial Plates |
| Yes | No | Swan-Ganz or Thermodilution Catheter | Yes | No | Breathing Problem/ Motion Disorder |
| Yes | No | IUD, Diaphragm, or Pessary | Yes | No | Hearing Aid (remove before entering MR Room) |
| Yes | No | Other Implant? _____ | Yes | No | Claustrophobia |
| Yes | No | Have you <u>ever</u> had metal fragments in your eyes or skull? | | | |
| Yes | No | Are you Pregnant, Possibly Pregnant or Breast Feeding? | | | |

I attest that the above information is correct.

Patient Signature _____ **Guardian** _____ **Date** _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have received a copy of the Notice of Privacy Practices.

Signature of patient or personal representative

If signed by personal representative, relationship to patient

Date



Office Use Only:

Our practice will make a good faith effort to obtain a written acknowledgment of receipt of the Notice provided to the individual. If written acknowledgement is not obtained our practice must document its good faith efforts to obtain such acknowledgement and record the reason why the acknowledgement was not obtained.

Refused to Sign Physically unable to Sign

(Other) _____

Employee Signature _____ **Date** _____

MEDICAL RELEASE FORM

I hereby authorize and request you to release to:

**Thumb MRI Center
6320 Van Dyke
Cass City, MI 48726
Telephone: 989-872-8070
Fax: 989-872-5734**

The complete history of records in your possession concerning my illness and/or treatment.

Your name _____ Date _____

Your address _____

Your Date of Birth _____

Your Signature _____

Witness _____

FOR THUMB MRI PERSONNEL (Be specific in what reports you are looking for)

Company Name _____ From _____

Attention _____ Date _____

Fax Number _____ Phone Number _____

Comments _____

Effective Date: April 14, 2003

This notice describe how medical information about you may be used and disclosed and how you can get access to this information.

Understanding Your Health Record/Information

Each time you visit our Office, or another physician or health care provider contacts us concerning your medical needs or history, a record is made by our Office. This record contains medical information generated during your visits to our Office, received by our Office from other health care providers, or provided by you. In this "Notice of Health Information Practices," we shall refer to the information contained in your record as your "health information." This term shall have the same meaning as "protected health information" defined in the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA").

Your Health Information Rights

Within the limits provided by federal and state law, you have the right to:

- Request restrictions on certain uses and disclosures of your health information;
- Receive confidential communications of your health information. You may request that we communicate with you about your health information by alternative means or at an alternative location;
- Inspect and obtain a copy of your health information, except with regard to psychotherapy notes or information compiled in reasonable anticipation of certain civil, criminal or administrative proceedings;
- Request an amendment to your health information that we have created, except with regard to those portions of your health information that you are precluded from inspecting and copying as set forth above;
- Obtain an accounting of certain disclosures of your health information; and
- Receive a paper copy of this Notice in addition to any electronic copy you may receive.

You may exercise any of the above rights by submitting a signed letter detailing your request and mailing or delivering the letter to our Office Manager. However, we encourage you to call first so that we can help you be as specific as possible with your request. We will promptly provide you with forms needed to process your request.

Our Responsibility

This Office is required by law to:

- Maintain the privacy of your health information;
- Provide you with this Notice of our legal duties and privacy practices with respect to health information we collect and maintain about you;
- Abide by the terms of this Notice, currently in effect, and as amended from time to time;
- Notify you if we are unable to honor your request to restrict a use of disclosure of, or to amend, your health information; and
- Accommodate reasonable requests you may have to communicate your health information by alternative means or at alternative locations.

We reserve the rights to change our privacy practices and to make the new provisions effective for all of your health information we already have, as well as any health information we receive or create in the future. Should our privacy practices change, we will post a copy of the revised Notice in our waiting area, which indicates the effective date of the amended Notice. you may request and obtain a copy of our Notice of Privacy Practices anytime you visit our office.

If a use or disclosure of your health information is not permitted under law without a written authorization, we will not use or disclose your health information without that written authorization. You may at any time revoke a written authorization in writing, except to the extent that we have already taken action in reliance of you authorization.

For More Information or to Report a Problem

If you have questions and would like additional information concerning this Notice, please call Diane Ruhlman, Office Manager at 989-872-8070. If you believe that we have violated any of your privacy rights, you may file a written complaint with our Office Manager, or mail your written complaint to Thumb MRI Center 6320 Van Dyke Road, Cass City, MI. 48726. You may also file your complaint with the Secretary of Health and Human Services. There will be no penalty or retaliation for filing a complaint.

Examples of Uses and Disclosures for Treatment, Payment and Health Operations

We will us your health information for treatment.

We will us your information to provide medical services to you. Any of our staff involved in your care will have access to your health information. We may also provide your health information to other care providers involved in your care to assist them in providing services to you.

We will use your health information for payment.

Your Health plan or health insurer will require certain information about your condition and the services you receive from us, before payment will be made, or for pre-authorization purposes. Accordingly, for billing purposes, we may disclose your health information to your health plan or health insurer. We also may disclose health information to your health plan or health insurer when they require pre-authorization of a recommended procedure.

We will use your health information for regular health care operations.

Members of our staff may review and use health information from your record to assess the care and outcomes in your case and others like it. This information will then be used by us in an effort to continually improve the quality and effectiveness our our services.

Additional Uses and Disclosure

Business Associates: Certain of our business operations may be performed by other businesses. We refer to these companies as "business associates." In order for these business associates to perform the required services (billing, accounting services, etc.), we may need to disclose your health information to them so that they can perform the job we've asked them to do. To protect you, we require our business associates to appropriately safeguard your health information.

Communication with Persons Involved in Your Care: Unless you object, we may release PHI about you to a family member, other relative, or a close personal friend of yours or any other person identified by you. We will disclose only PHI that is directly relevant to the person's involvement with your health care or payment related to your healthcare.

Required by Law: We may use or disclose your health information to the extent such use or disclosure is required by law and is limited to the relevant requirements of such law.

Public Health, Health Oversight and the Food and Drug Administration (FDA): As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability. We may also be required by law to disclose your health information to health oversight agencies responsible for regulating the health care system, government benefits programs, and civil rights law, so that they may conduct, among other things, audits, investigations, and inspections. For the purpose of activities relating to the quality, safety or effectiveness of inspections. For the purpose of activities relating to the quality, safety or effectiveness of a FDA-regulated product or activity, we may disclose to the FDA your health information relating to adverse events with drugs, supplements, and other products, as well as information needed to enable product recalls, repairs, or replacements.

Victims of Abuse, Neglect or Domestic Violence: If we reasonably believe that you are the victim of abuse, neglect or domestic violence, we may disclose your health information to a governmental authority responsible for receiving these types of reports, to the extent the disclosure is required by law, or you agree to the disclosure. If the disclosure is authorized by law, but not required, we may disclose your information if we determine the disclosure is necessary to prevent serious harm to you or others.

Judicial and administrative Proceedings: If you are involved in a judicial or administrative proceeding, we may, in response to an order of a court or administrative tribunal, or in response to a subpoena, information that are request, or other lawful process, disclose the specific portions of your health information that are requested. If the subpoena, discovery request or other lawful process is not accompanied by a court or administrative tribunal order, we may disclose your health information only after we are assured that reasonable efforts have been made to notify you of the request, and the time for you to raise objections to the request has expired, or reasonable efforts have been made by the requestor to seek a protective order concerning the requested health information.

Law Enforcement: We may disclose your health information to a law enforcement official for law enforcement purposes as required by law, a court ordered subpoena or summons, a grand jury subpoena or summons, or an administrative subpoena or summons, under certain circumstances. In specific situations, the law also permits us to disclose limited pieces of you health information, when the information is needed by law enforcement officials to:

1. identify a suspect, fugitive, material witness, or missing person;
2. identify a victim of a crime
3. alert law enforcement officials concerning your death;
4. notify law enforcement officials when a crime has been committed on our premises; or
5. in an emergency, when necessary to alert law enforcement officials about a crime, its location, or the identity of a perpetrator.

Inmates and Individuals in Custody: If you are an inmate or otherwise in custody, we may disclose your health information to the correctional facility or law enforcement officials having lawful custody of you.

Coroners Medical Examiners and Funeral Directors: We may disclose your health information to a coroner or medical examiner for the purpose of identifying you upon you passing, or to determine a cause of death. We may also disclose your health information to

your funeral director if needed to complete his or her authorized duties.

Avert a Serious Threat to Health Safety: Consistent with applicable law and standards of ethical conduct, we may, in limited circumstances, use or disclose your health information if we, in good faith, believe such use or disclosure is necessary to prevent or lessen a serious and imminent to health or safety of a person or the public.

Worker's Compensation: We may disclose your health information to the extent authorized and necessary to comply with laws relating to workers' compensation or other similar programs established by law.

Appointment Reminders and Information on Treatment Alternatives: We may contact you to provide appointment reminders, information concerning treatment alternatives or other health-related benefits, alternatives and services that may be of interest to you.