CHARTER RADIOLOGY
WHERE COMPASSION AND EXPERTISE COME TOGETHER

SCAN+ NOT SUPPORTED

MRI Screening Form

Name: **DOB:** **Age:** **Sex:**

Your preferred music during your scan (Genre / Artist / Album) : _____

Explain your symptoms and medical problem in detail.

_____

_____

Patient History

Height: _____ **Weight:** _____

Have you had prior MRI's/CT's related to your symptoms? ☐ Yes ☐ No If yes, where / when? _____

Have you had surgery to the body part being imaged? ☐ Yes ☐ No If yes, what type? _____

☐ Yes ☐ No History of Cancer or Tumors: When _____ Where _____

☐ Yes ☐ No History of Dialysis or Renal Insufficiency/Kidney Problems: _____

☐ Yes ☐ No Do you take medications for high blood pressure? _____

☐ Yes ☐ No Diabetic? ☐ Yes ☐ No Do you have allergies to any medications?

Do you have or have you ever had any of the following?

☐ Yes ☐ No **Cardiac Pacemaker / Defibrillator (If yes, we cannot perform exam)**

☐ Yes ☐ No Heart Surgery / Heart Valve

☐ Yes ☐ No **Brain Aneurysm Clips / Brain Surgery**

☐ Yes ☐ No **Neurostimulator / Biostimulator**

☐ Yes ☐ No Shunts / Stents / Filters / Coil

☐ Yes ☐ No Orthopedic Pins / Screws / Rods / Prosthesis

☐ Yes ☐ No Metal Mesh Implants / Wire Sutures

☐ Yes ☐ No Ear Surgery / Cochlear Implants / Hearing Aids

☐ Yes ☐ No Electrical / Mechanical / Magnetic Implants?

☐ Yes ☐ No For Shoulder Rotator Cuff Tears: Trapezius Transfer

☐ Yes ☐ No Circle: Gallbladder or Appendix removed

☐ Yes ☐ No **Do you use a Continuous Glucose Monitor? If yes, please remove.**

☐ Yes ☐ No **Implanted Drug Infusion / Insulin**

☐ Yes ☐ No Tattoos / Body Piercing / Patches

☐ Yes ☐ No Dentures / Partials / Dental Implants

☐ Yes ☐ No Gunshot Wounds / Shrapnel / BB

☐ Yes ☐ No Eye Surgery / Implants / Wires

☐ Yes ☐ No Have you ever done any welding or grinding within the last 5-6 months?

☐ Yes ☐ No Injury to the Eye Involving Metal / Metal Shavings

*******QUESTIONS FOR WOMEN ONLY*******

☐ Yes ☐ No Are you pregnant?

☐ Yes ☐ No Are you breast feeding at this time?

☐ Yes ☐ No Circle: Uterus or ovaries removed

☐ Yes ☐ No Do you have any implanted IUD?

MRI Safety- Charter Radiology uses 3T MRI wide bore at all of our locations to provide clear and vivid diagnostic images, with comfort. You will be entering a magnetic field and will be asked to remove all jewelry, piercings, accessories, hair pins/clips, compression fabrics, medication patches/monitors, bra/sports bra. You will be provided scrubs or gown to change into and a locker to keep your belongings secure**. Please inform your technologist if you have any implanted metal or devices they should know about. Please note: MRI screening form should be frequently updated as safety status can change.**

************** For comparison purposes, please provide CD and report of any outside prior imaging **************

_____ _____

Signature of Patient or Authorized Representative Date

_____ _____

Witness/Technologist Date

CHARTER RADIOLOGY

PATIENT INFORMATION & BILLING AUTHORIZATION

PATIENT: _____

Last Name First Name Middle Name

_____

Sex Date of Birth

ADDRESS: _____

Street City State Zip Code

PHONE: _____

Home Phone Cell Phone ****E-MAIL FOR PATIENT PORTAL****

INSURANCE: _____

Company Policy Number Group Number

_____

Name of Policy Holder Date of Birth Policy Holder Sex

Secondary: _____

Secondary Policy Number Group Number

_____

Name of Policy Holder Date of Birth Policy Holder Sex

Referring provider(s): _____

List primary care physician or any other doctors to receive your reports: _____

(First and last name)

(____) **MEDICARE (initial if you are covered by Medicare)** I request that payment of authorized Medicare benefit be made to CHARTER RADIOLOGY LLC for any services they furnished to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. In Medicare assigned cases, the physician or supplier agrees to accept the Medicare allowed amount. The patient is responsible only for the deductible, coinsurance, and any non-covered services. Coinsurance and the deductible are based on the charge determination of Medicare Carrier.

(____) **MEDICAL INSURANCE (initial if you are covered by any medical insurance. This also includes Medigap, Worker's Compensation or Personal Injury Protection benefits/Auto)** I authorize payment of medical benefits, otherwise payable to me, to CHARTER RADIOLOGY, LLC. I understand that I am financially responsible for charges not covered by this assignment. I authorize Charter Radiology LLC to release to my insurance company any medical information for processing of a claim. I authorize Charter Radiology LLC to obtain information pertaining to my insurance coverage and benefits from the carrier of same. I permit a copy of this authorization to be used in place of the original.

_____

Date **Signature** of patient or parent (if under age 18)

_____

Print full name of responsible party if patient is a minor

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AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this form, I acknowledge that I can request a copy of Charter Radiology's Notice of Privacy Practices which provides information about ways my protected health information ("PHI") may be used and disclosed by Charter Radiology and states my rights with respect to my PHI. I understand that Charter Radiology has the right to revise these practices and if the terms of the Notice of Privacy Practices change, a revised Notice will be made available to me. Please note: In accordance with Maryland Law, we may destroy patient charts 6 years after the last documented record. In the case of a minor, records, must be retained until the patient reaches the age of 18 plus 3 years, or for 5 years after the record was made, whichever is later.

In addition, by signing this form, I hereby voluntarily authorize the use and/or disclosure of all or any part of my PHI as described in this Authorization by Charter Radiology and its employees, agents, and third parties acting on its behalf as follows: (1) anonymous images of me may be used by Charter Radiology for teaching or educational purposes and (2) in order to facilitate the healthcare services provided to me, Charter Radiology may engage in the following:

- Call, email or send a text to me to confirm appointments Yes____ No____
- Leave a message on my home answering machine and/or cell phone Yes____ No____
- Discuss my medical condition with the following individuals: (i.e. relative or friend)

Name of Individual	**Phone Number**	**Email Address**
_____	_____	_____

My signature below means that I understand and agree to the following:

- My PHI may be protected by law. My PHI that is disclosed under this Authorization may be re-disclosed by the recipient and no longer protected by federal privacy regulations.
- Charter Radiology will not condition my treatment on whether I sign this Authorization.
- Without my signature below, this Authorization will not be honored.
- I may receive a copy of this form if I ask for it in writing addressed to Charter Radiology.
- This authorization will expire six (6) years from the date set forth below, unless I revoke it sooner. If I sign this form, I may revoke this Authorization at any time by notifying Charter Radiology in writing at the address below. Revoking this Authorization will not have any effect on actions that Charter Radiology took in reliance on the Authorization before it received notice of my revocation.

_____ _____

Signature of Individual or Representative Date

_____ _____

Printed Name of Individual Relationship to Individual (if signed by Personal Representative)