23832 SOUTHFIELD ROAD SOUTHFIELD, MI 48075 P: 248.327.7512 F:248.262.7379 MAXIMMRI.COM	31150 HOOVER RD. SUITE D WARREN, MI 48093	25100 KELLY RD. SUITE B ROSEVILLE, MI 48066

PATIENT INFORMATION **TODAY'S DATE**: _____

LAST NAME:	FIRST NAME:	MIDDLE INITIAL:
ADDRESS:	CITY:	STATE & ZIP:
HOME PHONE:	WORK PHONE:	CELL PHONE:
BIRTH DATE:	AGE:	SOCIAL SECURITY NUMBER:

MARITAL STATUS (CIRCLE ONE) SINGLE MARRIED DIVORCED WIDOWED SEX: MALE FEMALE

EMAIL ADDRESS:

EMERGENCY CONTACT PERSON: _____ PHONE: _____

RELATIONSHIP: _____

ARE YOU CURRENTLY WORKING? (CIRCLE ONE) YES NO

IF NO, WHAT WAS YOUR LAST DAY OF WORK: _____

EMPLOYMENT INFORMATION

EMPLOYER NAME:	PHONE:	YOUR OCCUPATION:
ADDRESS:	CITY:	STATE &ZIP

REFERRING DOCTOR OR INDIVIDUAL

NAME:		PHONE:
ADDRESS:	CITY:	STATE & ZIP

CHIEF COMPLAINT:

PRIMARY CARE PHYSICIAN

NAME:		PHONE:
ADDRESS:	CITY:	STATE & ZIP

IS YOUR CHIEF COMPLAINT THE RESULT OF AN AUTO ACCIDENT?

☐YES ☐NO STATE AUTO ACCIDENT OCCURRED IN:_____

WAS A POLICE REPORT FILED? ☐YES ☐NO IF YES, PLEASE PROVIDE A COPY

IS YOUR CHIEF COMPLAINT THE RESULT OF A WORK INJURY? ☐YES ☐NO IS YOUR CHIEF COMPLAINT THE RESULTS OF A SLIP AND FALL? ☐YES ☐NO	
PLEASE EXPLAIN IN DETAIL HOW YOUR INJURY/ACCIDENT HAPPENED: _____ _____ _____	
WHAT IS THE DATE OF YOUR INJURY?	
WHAT IS YOUR ATTORNEY'S NAME?_____ PHONE NUMBER:_____ N/A ☐	
CASE MANAGER INFORMATION	
CASE MANAGER AND COMPANY NAME:	PHONE:
ADJUSTOR INFORMATION	
NAME:	PHONE:
CLAIM NUMBER:	POLICY HOLDER'S NAME:
PRIMARY INSURANCE INFORMATION	
INSURANCE COMPANY'S NAME:	
SUBSCRIBER'S NAME:	SUBSCRIBER'S DATE OF BIRTH:
SUBSCRIBER'S CONTRACT/CLAIM NUMBER:	SUBSCRIBER'S GROUP NUMBER:
SUBSCRIBER'S RELATIONSHIP TO PATIENT (CIRCLE ONE) SELF SPOUSE DEPENDENT	
SUBSCRIBER'S EMPLOYER, OR RETIRED FROM:	
EMPLOYER'S ADDRESS:	PHONE:
SECONDARY INSURANCE INFORMATION:	
INSURANCE COMPANY'S NAME:	
SUBSCRIBER'S NAME:	SUBSCRIBER'S DATE OF BIRTH:
SUBSCRIBER'S CONTRACT/CLAIM NUMBER:	SUBSCRIBER'S GROUP NUMBER:
SUBSCRIBER'S RELATIONSHIP TO PATIENT (CIRCLE ONE) SELF SPOUSE DEPENDENT	
OTHER INSURANCE INFORMATION:	**PHONE:**

PATIENT HISTORY QUESTIONNAIRE

Patient Name:_____Age:_____Height:_____Weight:_____

Type of Exam:_____Date:_____

Please read the following form carefully:

It is important for us to know your medical history, so our Radiologist and staff can utilize certain scanning protocols we have in place for your safety.
If you have any questions please ask us to explain. Thank you for allowing us to serve you today.

What type of problems or symptoms are you experiencing?

_____
_____
_____

List all Surgeries you have had:

_____
_____
_____
_____

Recent Injury or Trauma? _____
Personal History of Cancer: _____

History of Seizures: Y/N Confusion: Y/N Blurred vision: Y/N Head Injury: Y/N Stroke: Y/N
Dizziness/Vertigo: Y/N Slurred speech: Y/N Memory loss: Y/N Weakness: Y/N Liver disease: Y/N
Diabetic: Y/N

If you answered YES to any of the above please explain and give date(s):

_____
_____
_____

I have read this form in its entirety or had someone read it to me. The exam has been explained to me and all my questions have been answered.

Signature: _____Date: _____

Screening Form

Patient Name: _____Age: _____ Sex: M or F

WARNING: Certain implants, devices or objects may be hazardous to you in the MRI environment or MR system room. DO NOT ENTER the MR environment or MR system room if you have any questions or concerns regarding an implanted device or object. Please answer the following questions below.

Do you have a heart pacemaker?	Y	N	Is there a possibility of metal in your head, e.g. aneurysm clips?	Y	N
Is there a possibility of metal in your eyes, or have you ever needed an eyewash due to working with metals?	Y	N	Do you have anemia or any disease(s) that affect your blood?	Y	N
Have you had metallic dental implants (posts, crowns) within the last six weeks?	Y	N	Have you had any bone, tendon, spine or joint surgery within the last six weeks?	Y	N
Have you ever been diagnosed with cancer?	Y	N	Claustrophobia?	Y	N
Bullets or shrapnel?	Y	N	Medical patch (Nicotine or Nitroglycerin)?	Y	N
Tissue Expander (e.g. breast)?	Y	N	Joint replacement or joint/bone pin, screw, nail, wire, or staple?	Y	N
Hearing aid? (remove before entering MR room)	Y	N	Breathing problem or motion disorder?	Y	N
Metallic stent, filter or coil?	Y	N	Do you have any piercings that cannot be removed?	Y	N
Do you have any medical problems when you lay flat on your back? (nausea, pain, breathing problems)	Y	N	Have you had any previous surgery on the area to be scanned? If yes, see history sheet.	Y	N
Tattoo or permanent makeup?	Y	N	Dentures or partial plate?	Y	N
IUD, diaphragm or pessary?	Y	N	Do you have a history of seizures?	Y	N
Are you pregnant or experiencing a late period?	Y	N	Are you currently breastfeeding?	Y	N
Do you have a history of Severe Hepatic Disease, liver transplant or pending transplant?	Y	N	Are you allergic to any medication? If so, explain:	Y	N
Do you have a history of hypertension?	Y	N	Do you have Diabetes Mellitus?	Y	N
Do you have a history of asthma, allergic reaction, respiratory disease, or reaction to contrast dye used for MR, CT or X-Ray examination?	Y	N	Do you have an implanted medical device? (Cochlear implant, metal ear tubes, TENS unit, bone stimulator, insulin, or other medical pump, automatic defibrillator pacing wires?	Y	N

I attest that the above information is correct to the best of my knowledge. I read and understand the content of this form, and had the opportunity to ask questions regarding the information on this form and regarding the MR procedure (s) that I am to undergo.

Signature:_____Date:_____

MRI SAFETY SCREENING QUESTIONNAIRE (OUTPATIENTS)

If you answered YES to any of the questions on the front page, please discuss any concerns and/or issues you may have, with you MR Technologist, MR Assistant or Radiology Nurse.

Instructions for the Patient, Parent, Guardian:

We will provide a locker so ALL items you remove may be stored and locked safely during your scan. You may bring the key into the scan room with you.

- Remove ALL jewelry including ALL body piercing jewelry and ALL hair accessories.
- Remove dentures, false teeth, partial dental plates, and retainers.
- Remove hearing aids and eyeglasses.
- Remove ALL clothing and change into hospital gown. Slippers will be provided.
- Lock your clothes and valuables in the locker provided and remove the key.
- Please use the restroom before your MRI exam.
- Please make sure that you receive a pair of earplugs and/or headphones before your MRI exam begins. Some patients may find the noise levels unacceptable, and the noise levels may affect your hearing.

I attest the above information is correct to the best of my knowledge. I have read and understand the entire contents of this form and I have had the opportunity to ask questions regarding the information on this form.

Patient/Parent/Guardian/Other Signature:_____ Date: _____

MR Tech/ MR Assistant/ RN Signature:_____ Date:_____

Printed Name of MR Tech/ MR Assistant/ RN:_____

FOR MRI STAFF ONLY

Contrast Type: _____ Injection Rate:_____ Injection Amount_____

Creatinine Value:_____ GFR Value:_____ Date Acquired:_____

Creatinine/GFR screening waived by:_____

MR Technologist/RN/MD Signature:_____

Radiologist Signature:_____ Date:_____

To be filed in Patient Medical Record

PATIENT RESPONSIBILITY FORM

1. INDIVIDUAL'S FINANCIAL RESPONSIBILITY

I understand that I am financially responsible for my health insurance deductible, co-insurance or non-covered service. Co-payments are due at time of service. If my plan deems a service to be "not payable", I will be responsible for the complete charge and agree to pay the costs of all services provided. If I am uninsured, I agree to pay for the medical services rendered to me at time of service.

2. INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

I hereby authorize and direct payment of my medical benefits to Maxim MRI on my behalf for any services furnished to me by the providers.

3. AUTHORIZATION TO RELEASE RECORDS

I hereby authorize Maxim MRI to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services as-well as information required for precertification, authorization or referral to another medical provider.

4. MEDICARE REQUEST FOR PAYMENT

I request payment of authorized Medicare benefits to me or on my behalf for any services furnished me by or in Maxim MRI. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits for related services.

Signature of Patient: _____Printed Name: _____ Date: _____

Patient Consent

I, _____, understand that as part of my health care, Maxim MRI originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment and plans for future care of treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my 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.

I acknowledge that a copy of the Michigan Imaging Notice of Privacy Practices was posted in a clear and prominent place where I was able to read the Notice of Privacy Practices. I know that I can request a copy and take it with me.

I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to object to use of my health information for directory purposes
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations.

I understand that Maxim MRI is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations. I further understand that Maxim MRI reserves the right to change its notice and practices in accordance with Section 164.520 of the code of Federal Regulation. Should Maxim MRI change its notice, it will post a new revised notice and provide a copy of any revised notice to me upon request.

I wish to have the following restriction(s) with regard to the use and disclosure of my health information:_____
_____

I understand that as part of this organizations treatment, payment or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I understand that this may include information relating to acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV) infection, behavioral health services/psychiatric care and treatment for alcohol and/or drug abuse. I fully understand and accept the terms of this consent.

Signature:_____Date:_____