Memorial MRI and Diagnostic **Stat or Routine**

Exam / Procedure: _____ **Chart #** _____

Date of Exam: _____ **Age:** _____ **Sex:** _____ **Date of Birth:** _____

Patient's Name:_____**Referring Physician:**_____

X-Ray / IVP, CT Scan, and Ultrasound: Patient History

☐ Yes ☐ No Have you had any surgeries? If yes, explain? _____

Where? _____

☐ Yes ☐ No Do you have any pain? If yes, where is the pain at and where is it radiating to?

_____

☐ Yes ☐ No Do you or have you ever had cancer or tumor? _____

☐ Yes ☐ No Are you diabetic? Type of medication taking: _____

☐ Yes ☐ No History of kidney failure?

☐ Yes ☐ No History of heart disease?

☐ Yes ☐ No History of Seizures / Headaches / Dizziness How Long? _____

☐ Yes ☐ No History of sickle cell anemia / Blood Disorder?

☐ Yes ☐ No History of asthma? History of Hypertension ☐ YES ☐ NO

☐ Yes ☐ No History of Liver Disorder?

☐ Yes ☐ No History of unstable angina?

☐ Yes ☐ No History of recent heart attack?

Explain your medical problem in details (What is the problem? Where is the problem? How long have you had the problem?):

_____

_____

_____

Is your problem related to an injury, trauma, or auto accidents? Yes No.
If yes, date of injury? _____Please give a detailed description on how you were injured?

_____

_____

For Female Patients Only: Pregnancy Release

To the best of your knowledge are you pregnant? ☐ YES ☐ NO Date of Last Menstrual Cycle? _____

I am aware that having an X-ray or CT exam while pregnant could be harmful to an unborn baby. It is my understanding that protective shielding will be used when applicable and hereby gives my consent for Memorial MRI and Diagnostic to perform the X-Ray / CT Scan which my physician has prescribed.

Patients Initial: ***IF NOT SURE PLEASE INFORM THE FRONT DESK FOR A PREGNANCY TEST**

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

Signature (Parent or Guardian)

_____

Date Signed: _____

Memorial MRI and Diagnostic

Date of Exam: _____ Patient's Name: _____

Procedure: _____DOB: _____Referring Physician: _____

Contrast Consent for CT and IVP

Your procedure today requires the use of an injection contrast material. We use non-ionic contrast. This material is injected intravenously and contains iodine. However, the non-ionic contrast has proven to be more tolerable for the patients than the previously used ionic ones.

It is to be administered to provide contrast enhancement and make it easier to see areas of concern or interest, such as blood vessels and scar tissue. Some reactions such as nausea, vomiting, change in blood pressure, skin rash, or other more severe reactions may occur but are uncommon with the non-ionic contrast material. However there are possible, but infrequent, complications from these procedures such as bleeding, pain, tenderness, swelling, or infection at injection site(s), extravasations at injection site, renal damage, and severe systematic reactions (anaphylactic shock, drug reaction, or death)

Some insurance companies do not always cover all or even part of this product. We will charge only for the amount used in your procedure.

I have read the above statement regarding non-ionic contrast and give consent for the use of contrast during my procedure. All of my questions regarding contrast and potential reactions have been answered to my satisfaction.

I understand that I am financially responsible for the cost of the contrast even if my insurance denies all or part of the charge.

Please fill out completely:

Are you allergic to any Medication or Food? □ **YES** □ **NO**

If so, please specify medication / food you are allergic to:

_____

Have you ever had any procedures with iodine injected before: □ YES □ NO

If so, are you allergic to Iodine? □ **YES** □ **NO**

If Yes, describe Reactions in Detail: _____

_____

Are you allergic to Shellfish or Seafood? □ **YES** □ **NO**

If Yes, describe Reactions in Detail: _____

_____

CT Technologist Must Fill Out: – Patient Do Not Complete

CT Oral Contrast Used: Yes or No Type: _____ Amount: _____

CT Non-Ionic Contrast Used: Yes or No Type: _____ Number if CC's Used: _____

BUN: _____ Creatine: _____

Notes: _____

Technologist Signature: _____

I have read and understand the entire contents of this form and have had the opportunity to ask questions regarding the information on this form and consent to the procedure.

Patient Signature (or Guardian)

_____

MEMORIAL MRI & DIAGNOSTIC

Patient's Name: _____ Sex:_____ DOB: _____

SS# _____ Address: _____

City /State/ Zip: _____

Home #: _____ Work #: _____ Cell #: _____

Insurance Name: _____ ID#: _____ Group #: _____

Primary Card Holder if not Patient: _____DOB: _____

SS# _____WORKER'S COMP INFO: Employer: _____

Date of Injury: _____Address: _____ City / State/ Zip: _____

Contact Person: _____ Work #: _____ Fax #: _____

Attorney's Name: _____ Office #: _____ Fax #: _____

Treatment & Insurance Authorization

Authorization for Release of Information and Assignment of Benefits

I hereby consent to treatment by the attending physician and other medical staff for all local anesthetics, tests, surgical and other medial procedures as deemed necessary by myself and the medical staff.

Authorization for Treatment

I hereby assign to the above named office, those benefits otherwise payable to me and by any third party as reimbursement of expenses and fees in connection with treatment rendered.

I request that payment of authorized benefits be made directly to the medical provider named above on my behalf.
I FULLY UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY AND ALL AMOUNTS NOT OTHERWISE PAID BY MY INSURANCE CARRIER.
I certify that the information on this form given by me for payment under title XVIII (Medicare) is correct and complete. I authorize the holder of medical or related information about me, to be released to the HealthCare Finance Administration or other health care coverage entity, and information needed for this or any related health care claim in writing or verbally. I further understand and agree to pay for services or amounts due when appropriate. These charges could include amounts applied to my annual deductible co-payment amounts, and charges denied as not covered by my insurance program or deemed medically unnecessary. I understand that well cared is not covered by Medicare or many other health insurance programs.

PATIENT SIGNATURE:_____Date: _____

Medical Records Authorization

I hereby authorize the release of my films and /or medical records as needed for subsequent medical care. In the eve nt of postive findings, I authorize my attending physician to release the results of my biopsy-surgery to the provider named above for their records.

I hereby request that any MEDICAL RECORDS be released to:

MEMORIAL MRI & DIAGNOSTIC
1346 Campbell Road
Houston, Texas 77055
Office #: 713-461-3399 Fax #: 713-461-1969

MEMORIAL MRI & DIAGNOSTIC
1241 Campbell Road
HOUSTON, TEXAS 77055
Office #: 713-461-3399 Fax #: 713-461-1969

IF SOMEONE OTHER THAN THE PATIENT IS SIGNING THIS AUTHORIZATION, PLEASE STATE RELATIONSHIP WITH PATIENT AND THE REASON PATIENT IS UNABLE TO SIGN: _____
_____

Office Use Only: Information Requesting: ☐ MRI REPORTS ☐ MRI FILMS ☐ ULTRASOUND REPORTS ☐ ULTRASOUND FILMS ☐ NUCMED FILMS ☐ NUCMED FILMS ☐ CT REPORTS ☐ CT FILMS ☐X-RAYS/FLOURO REPORTS ☐ X-RAYS/FLOURO FILMS ☐ Other Healthcare Information to the following treatment, condition, or date of treatment:

DATE:

YOUR COPY TO KEEP…….

Memorial MRI & Diagnostic

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Protecting your privacy

Protecting your privacy and your medical information is at the core of our business. We recognize our obligation to keep your information secure and confidential whether on paper or the Internet. At **Memorial MRI & Diagnostic (hereinafter referred to as "the Practice"),** privacy is one of our highest priorities.

Keeping your information

Keeping the medical and health information we have about you secure is one of our most important responsibilities. We value your trust and will handle your information with care. Our employees access information about you only when necessary to provide treatment, verify eligibility, obtain authorization, process claims and otherwise meet your needs. We may also access information about you when considering a request from you or when exercising our rights under the law or any agreement with you.

We safeguard information during all business practices according to established security standards and procedures, and we continually assess new technology for protecting information. Our employees are trained to understand and comply with these information principles.

Working to meet your needs through information

In the course of doing business, we collect and use various types of information, like name and address and claims information. We use this information to provide services to you, to process your claims and to bring your health information that might be of interest to you.

Keeping information accurate

Keeping your health information accurate and up-to-date is very important. If you believe the health information we have about you is incomplete, inaccurate or not current, please call or write us as the telephone numbers or addresses listed below. We take appropriate action to correct any erroneous information as quickly as possible through a standard set of practices and procedures.

How – and why – information is shared

We limit who receives information and what type of information is shared.

- *Sharing information within **the Practice.*** We share information within our company to deliver you the health care services and the related information and education programs specified in your plan.
- *Sharing information with companies that work for us.* To help us offer you our services, we may share information with companies that work for us, such as claim processing and mailing companies and companies that deliver health education and information directly to you. These companies that deliver health education and information directly to you. These companies act on our behalf and are obligated contractually to keep the information that we provide them confidential.
- *Other.* Patient-specific personally identifiable data is released only when required to provide a service for you and only to those with a need to know, or with your consent. Data is released with the condition that the person receiving the data will not release it further, unless you give permission.

If we receive a subpoena or similar legal process demanding release of any information about you, we will attempt to notify you (unless we are prohibited from doing so). Except as required by law or as described above, we do not share information with other parties, including government agencies.

The Practice does not share any customer information with third-party marketers who offer their products and services to our patients.

Count on our commitment to your privacy.
You can count on us to keep you informed about how we protect your privacy and limit the sharing of information you provide to us – whether it's at our office, over the phone or through the Internet.

Memorial MRI & Diagnostic
1346 Campbell Road

Memorial MRI & Diagnostic
1241Campbell Road

Memorial MRI & Diagnostic

NOTICE OF PRIVACY PRACTICES

Patient Consent and Acknowledgment of Receipt of Privacy Notice

I understand that as part of the provision of healthcare services, **Memorial MRI & Diagnostic** creates and maintains health records and other information describing among other things, my health history, symptoms, examination, and test results, diagnoses, treatment, and any plans for future care or treatment.

I have been provided with a Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their Notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations (quality assessment and improvement activities, underwriting, premium rating, conducting or arranging for medical review, legal services, and auditing functions, etc.) and that the organization is not required to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment and health care operations. I have the right to revoke this consent, in writing, except where disclosures have already made in reliance on my prior consent.

This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or health care operations without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this consent is as valid as the original.
3. I have the right to request that the use of my Protected Health Information, which is used or disclosed for the purposes of treatment, payment or health care operations be restricted. I also understand that the Practice and I must: agree to any restriction in writing that I request on the use and disclosure of my Protected Health Information; and agree to terminate any restrictions in writing on the use and disclosure of my Protected Health Information which have been previously agreed upon.

(PATIENT'S NAME PRINTED) _____ **DATE** _____

PATIENT'S SIGNATURE (OR GUARDIAN, IF A MINOR) _____ **DATE** _____