Last Name: _____ Acct # :

First Name: _____ Age: _____ Weight: _____

Physician Ordering MRI Exam: _____ Area to be Scanned: _____

Your medical information is confidential and protected by law. Accurate answers are necessary to ensure your safety and the correct interpretation of your exam.

YES	NO	
☐	☐	Do you have a **Pacemaker**, Implanted Defibrillator or Cardiac Wires
☐	☐	Aneurysm Clips in the Brain
☐	☐	Any Electronic, Magnetic or Mechanically activated implant or device in the body.
☐	☐	Have you ever had a metallic object in the eye? (Metal Slivers, Welding Fragment, etc…)
☐	☐	Any Vascular Clip, Filter, Stent or Shunt
☐	☐	Ear Implant, Stapes or **Cochlear Implant**
☐	☐	Eye Implant or Prosthesis
☐	☐	Joint Replacement, Screws, Pins, Clips
☐	☐	Hearing Aid, Removable Dental Work, TENS Unit
☐	☐	Body Piercings near area to be scanned. (Some exams require removal)
☐	☐	Is there any other metal that may be inside your body? _____
☐	☐	**Females** Are you currently pregnant?
☐	☐	Are you currently nursing?
☐	☐	Are you wearing eye make-up? (Remove for Brain scans)
☐	☐	Have you ever had a Cancer or Tumor in the body? _____
☐	☐	List any surgery you have had in the last six weeks: _____
☐	☐	Have you had a MRI exam before? Date: _____ Location: _____

Please list other imaging you have had *related to today's exam:* *Circle:* X-Ray C.T. Ultrasound Nuc Med

List Where and When: _____

Briefly describe your symptoms; reason for today's exam: _____

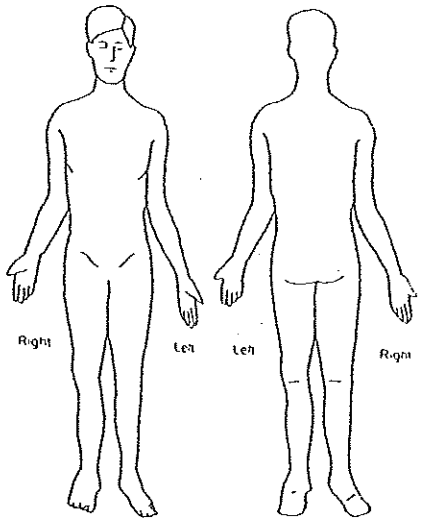
_____

Symptoms started _____ Is this the result of an injury or accident? _____ Date: _____

Have you had Surgery on the Region to be scanned? YES NO Date: _____

Describe: _____

Label the location of your symptoms, or Region of Interest on this figure:



Signature of Patient/ Guardian: _____

Date: _____ Technologist Initial: _____

Patient Information

Name _____ Male _____ Female _____

Date of Birth _____ Social Security _____

Mailing Address: _____

City _____ State _____ Zip _____

Phone #'s: Home _____ Cell _____ Work _____

Emergency Contact: Name _____ Phone # _____

Marital Status: Single ____ Married ____ Divorced ____ Widowed ____ Spouse Name: _____

Employer : _____

Primary Insurance Patients relationship to policy holder: Self____ Spouse ____ Child ____ Other ____

Insurance Co: _____ ID# _____ Group _____

Policy Holder _____ DOB _____ SS# _____

Policy Holder Employer _____

Employment Status: Full time ____ Part Time ____ Retired ____ Unemployed ____ Student ____

Secondary Insurance / Workman's Comp Information/ or Attorney

Insurance Company _____ ID# _____ Group _____

Policy Holder _____ DOB _____ SS# _____

Claim # _____ Claims Address: _____

Date of Injury _____ **Attorney Name & #** _____

Release of Medical Records To complete my insurance claim and treatment, I authorize MRI of Arizona to release my medical records to my records to my physician (s), clinic, hospital or insurance company (including government programs).
HIPPA – Notice of Privacy Practices I acknowledge that a copy of the Notice of Privacy Practices that outlines how patient confidential information will be used, disclosed, protected and how I can get access to this information, is available to me upon request.
Financial / Insurance Policy I hereby assign all insurance benefits to MRI of Arizona for services performed, as a result of my illness or injury. Non-insured patients. I agree that I am responsible for payment at the time of service, unless prior arrangements have been made. Deductible / Coinsurance. I assume and agree to pay all applicable deductibles and co-pays. If my deductible is not met, full payment will be collected at time of service. If my deductible is not met, my coinsurance amount will collected at time of service. Non-covered procedures. I agree to pay for all non-covered services (preventive or routine) not paid by my insurance. Collections. Once an account is placed in collection status all future services must be paid in full at the time of service. I understand that there will also be a $25.00 returned check fee.
Film Policy As a referred patient to MRI of Arizona, I understand that I am entitled to one set of films/disc per exam upon request of a referring physician. This set of films/disc belongs to me, the patient and is part of my medical records. Every additional set of films will cost $30.00 per procedure. I understand that MRI of Arizona requires 24 hour notice to print films.
Referral & Insurance Card Patient Responsibility I understand that during the check in process, if I do not have my referral and/or insurance card I will be responsible for any payment rendered at the time of service. I also understand that I can avoid this expense by bringing my referral and/or insurance card to my scheduled check in time or I understand that I can call my referring Doctor's office and have these items faxed to MRI of Arizona's front office at (602) 294-9012 before my scheduled exam time. I have read and agree to abide by.

Print Patient Name **Patient/Responsible Party Signature** **Date**

Nombre: _____ **PESO:**_____ **EDAD:**_____

Tiene usted:

Do you have

Si **No**

_____ _____ - **algun mechanismo implantado**
mechanical implant

_____ _____ - **como un marcapasos cardiaco**
cardiac pacemaker

_____ _____ - **una pinza para un aneurisma cerebral**
aneurysm clip

_____ _____ - **un audifono**
hearing aid

_____ _____ - **Esta embarazada?**
Are you pregnant?

_____ _____ - **Bomba de insulina**
insulin pump

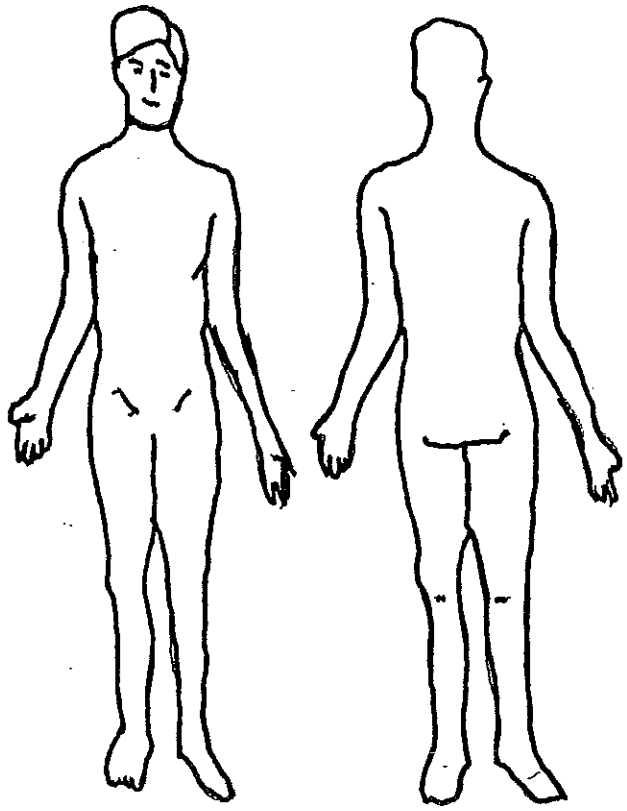
_____ _____ - **Gragmentos de metal en la piel**
metal fragment in eye

_____ _____ - **implante cochlear**
cochlear implant

_____ _____ - **Dentaduras**
dentures

Por favor, divuja la parte de tu cuerpo que te duele:

please shade in the areas which hurt



1. **Haga una listas de metales en el cuerpo:** *(List all metal in body)* _____

_____

2. **Que es el motivo que usted vio a su doctor?** *(Reason for Doctor visit)* _____
3. **Cuando comenso su problems?** *(When did problem start)* _____
4. **A tenido operaciones en la parte del cuerpoque to estamos examinando?** _____
(Have you had surgery on the body part we are scanning)?
5. **Tiene cancer, o a tenido cancer? Donde?** _____
(History of cancer? Where?)
_____
6. **Haga una lista de las operaciones que te an heco:** *(list of surgeries)* _____

Firma _____ **fecha de hoy** _____

Technologists Initials _____

MRI of Arizona

Pt. Number _____
Date _____

Patient Information

Nombre _____ Varon Hembra

Domicilo _____

Ciudad _____ Estado_____

Numero de distrito postal _____

Telefono ( ) _____ Empleo telefono ( )_____

Seguro Social _____ Fecha de Nacimiento _____

Estado Civil _____ C S V

Nombre del Patron _____

Nombre de su Doctor _____

Nombre de su Abogado _____

Fecha de Accidente _____

Seguro Salud _____

Poliza de seguro _____ Grupo # _____

Nombre de asequrado _____ Relacion _____

Fecha de nacimiento asequrado _____ Insured's Empleo _____

Secundario seguro salud _____

Poliza de seguro _____ Grupo # _____

Firma _____ Fecha de Hoy _____

MRI of Arizona

www.MRIofArizona.com

701 West Glendale Avenue
Phoenix, AZ 85021-8629
Tel: (602) 294-9009 • Fax: (602) 294-9012

AVISO DE LA FORMA PACIENTE DEL CONSENTIMIENTO DEL RECONCIMIENTO DE LAS PRACTICAS DE LA AISLAMIENTO

Entiendo que, bajo acto de la portabilidad y de la responsabiliadad del seguro medico de 1996 ('HIPPA'), tengo ciertas derechas a la aislamiento con respecto a mi informacion portegisa de la salud. Entiendo que esta informacion puede y sera :

- La conducta, plan y dirige mi tratamiento y carta recordative entre los abastecedores multiples del healthcare que pueden estar implicados en ese tratmiento directamente e inderectly.
- Obtenga el pago de pagadores de tercera persona por el pago que authriza de ventajas medicas a MRI del Arizona y de lanzar de cualquier informacion medica necesaria para procesar esta demanda.
- Conduzca las operaciones normales del healthcare tales como gravamenes de la calidad y certificaciones del medico.

Usted me he informado o he recibido, leo y entiendo que su aviso de la aislamiento practica el contener de una descripcion mas completa de las aplicacionas y de los accesos de mi informacion de la salud. Entiendo que esta organizacion tiene la derecha de cambiar su avso de las practicac de la aislamiento a partir de tiempo al tiempo y que puedo entrar en contacto con esta organizacion en cualquier momento en la direccion arriba para obtener una copia actual del aviso de las practicas de la aislamiento.

Entiendo que puedo solicitar como mu informacion privada se utiliza o se divulga para realizar el tratamiento, el pago u operaciones del cuidad medico. Tambien entiendo que le no requieren con venir mis restriccones soliciradas, sino que si usted entonces conviene usted sea limitado para habitar por tales recticciones.

Nombre Paciente :_____ Fecha :_____

Firma : _____

Testigo : _____

Relacion al Paciente : _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledge, but was unable to do so as documented below:

DATE:	INITIALS:	REASON: