SPRING HILL MRI

Patient Name: _____ PT #: _____

Home Phone: (_____) _____ - _____ Alternate Phone: (_____) _____ - _____ EXT:_____

Address: _____ Apt # : _____

City: _____ State:_____ Zip: _____

Social Security #: _____ **Date of Birth:** _____ **Age:** _____ **Sex**_____

Drivers License: _____ Marital Status: S / M / W / D Spouse Name:_____

Emergency Contact: _____ Phone:(_____) _____ - _____

PATIENT HISTORY – ALL PATIENTS

Today's Date: _____ What is your current weight:_____

Please describe the symptoms you are experiencing:_____

1. Do you have any of the following:

☐ **Cardiac Pacemaker**	☐ Cochlear(EAR) Implant or Prosthesis	☐ **Hearing Aids**	☐ **Neurostimulators**
☐ Infusion Pumps	☐ Dentures/Partials/Braces/Retainer	☐ **Intracranial Aneurysm Clips**	☐ **Patch (nicotine, pain, etc)**
☐ Shrapnel/Bullets	☐ Orbital Implant or Prosthesis	☐ Prosthetic Heart Valve	☐ Metal Fragments in Eye
☐ Intrauterine Device	☐ Inferior Vena Cava (IVC) Filter/Umbrella	☐ Penile Implant	

OR- ☐ **I attest that I DO NOT have any of the above**

2. Have you ever had surgery? ☐ No ☐Yes, list: _____

_____

3. Are you taking any medications? ☐ No ☐Yes, list: _____

_____

4. Are you allergic to any medications? ☐No ☐Yes, list: _____

5. For **Women ONLY**, is there a possibility of pregnancy? ☐ No ☐ Yes ☐Not Applicable

6. Is this a result of an injury?: ☐ No ☐ Yes: Date of Injury: _____

Was the injury a result of: ☐ Auto Accident ☐ Work Related Injury ☐ Slip and Fall ☐ Other:_____

State Vehicle Registered: _____

Briefly describe what happened? _____

_____

PATIENT HISTORY – MAMMOGRAPHY PATIENTS ONLY

1. Do you have breast implants? ☐No ☐Yes
2. Do you have a history of breast surgery? ☐No ☐Yes
3. Do you have a personal history of breast cancer? ☐No ☐Yes
4. Do you have a family history of breast cancer? ☐No ☐Yes
   If yes, what relation: _____
5. Do you have a personal history of ovarian cancer? ☐No ☐Yes
6. Do you have a family history of ovarian cancer? ☐No ☐Yes
   If yes, what relation: _____
7. Do you take any hormone medications? ☐No ☐Yes
   If yes, What type: _____How long:_____
8. Date of last menstrual period:_____
9. Date of last mammogram:_____
10. Where:_____

Reason for Today's Exam

Screening	☐RT	☐LT
Pain	☐RT	☐LT
Lump	☐RT	☐LT
Nipple Discharge	☐RT	☐LT

Other: _____

_____

I agree that all the information on this form is true and accurate to the best of my knowledge.

_____ _____ _____

Signature Printed Name Date

MRI ASSOCIATES OF SPRINGHILL, INC.
AUTHORIZATION AND AGREEMENTS
FOR MRI / MRA / CT / X-RAY / ULTRASOUND / MAMMOGRAPHY / DEXA SERVICES

Patient Name: _____

The undersigned hereby makes the following Acknowledgment and Agreement regarding the MRI/MRA/CT/X-Ray/Ultrasound/Mammography/DEXA services to be provided to the patient whose name appears above.

CONSENT FOR MRI / MRA / CT / X-RAY / ULTRASOUND / MAMMOGRAPHY / DEXA TECHNICAL/PROFESSIONAL SERVICES

I understand that services rendered are necessary for the patient by the above company and its physicians. I hereby consent to and authorize the administration of the MRI/MRA/CT/X-Ray/Ultrasound/ Mammography/DEXA study that may be considered advisable or necessary in the judgement of the referring physician. I authorize any medical records may be obtained by the above companies.

ENHANCEMENT CONSENT

Your doctor may order an image enhancement agent to be used for your MRI/MRA/CT. This agent makes the details of the MRI/MRA/CT clearer and does not mean your condition is more serious or that there is anything additionally wrong with you. We are asking your consent to use the enhancement only if your doctor has requested this use, or if it is deemed medically necessary.

AGREEMENT TO PAY FOR SERVICES

For and in consideration of the services provided to the patient, I promise to pay the above company for all charges and services rendered to or in behalf of the patient. The above company may secure any credit information that may be necessary. I also understand that I may be insured through a PPO/HMO plan and that it is my responsibility to obtain the proper and necessary referrals from my primary care physician before services are rendered. The above company shall make all reasonable efforts to assure that the insured is covered by the plan, but ultimately I understand that it is my responsibility.

DIRECT PAYMENT AUTHORIZATION

By way of original or a copy hereof, the undersigned patient hereby directs the applicable personal injury protection or medical payments insurance carrier to make payment directly to the above companies. If payment is made out to the above company they have the authorization to endorse the payment with the patient's signature along with its own.

RELEASE OF INFORMATION

I hereby authorize the above company to release any information in the course of my treatment to my insurance company or any physician needing this information for treatment.

COLLECTION OF ACCOUNT

I understand that if this account is assigned to an attorney for collection and/or suit, the above company shall be entitled to reasonable attorney's fees and cost of collection. I also understand that if any bad check is written, I am to pay only by cash, money order or credit card to redeem that check and if added cost is incurred to the above company I agree to pay for those fees.

_____ _____

Signature of Patient/Responsible Party Date

SPRING HILL

CONSENT OF DISCLOSURE

(For the Usage and / or Disclosure of Protected Health Information)

I hereby give consent to MRI Associates of Spring Hill, Inc. D/B/A Spring Hill MRI to use and disclose my protected health information (PHI) for the purposes of treatment, payment and health care operations.

You may cancel this consent at any time. Your cancellation must be in writing, signed by you or on your behalf, and delivered to the address at the bottom of this form. This may be delivered in person by mail, but it will only be effective when we actually receive it. Your cancellation will not be effective to the extent that we or others have acted in reliance upon this consent.

You have the right to request restriction on the usage and disclosure of your protected health information for the purposes of treatment, payment or health care operations. We are not required to grant your request, however, if we do, the restriction will be obligatory to us.

Our Posted Privacy Policy provides more detailed information about the usage and disclosure of your protected health information. You have the right to review our Posted Privacy Policy before you sign this consent.

We reserve the right to amend the terms of our Posted Privacy Policy. You may obtain a copy of the current policy by calling us at (352) 684-2811.

Print Name of Patient: _____

Sign: _____Date: _____

If you are signed as the patient's representative:

Print your Name: _____

Relationship: _____

SPRING HILL

♦

Authorization for Records Release

Patient Name: _____ Acct #: _____

Date of Birth: _____ Social Security #: _____

I hereby authorize Spring Hill MRI access to my medical records with respect to my medical condition or treatment. These records are being requested to assist in the continuity of my patient care at Spring Hill MRI. I understand that I may revoke the authorization at any time, and in order to do so, I must send written notice to the healthcare provider(s).

Signature: _____ Date: _____

I hereby authorize Spring Hill MRI to release or disclose my medical records to the following people:

_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Name	Relationship

I understand that I may revoke the authorization at any time, and in order to do so, I must send written notice to the healthcare provider(s).

Signature: _____ Date: _____