Patients Name: _____

Street Address: _____

City/State/Zip Code: _____/_____/_____

Home Phone #: _____-_____-_____

Cellular Phone #: _____-_____-_____

Social Security#: _____-_____-_____

Gender: MALE FEMALE

Marital Status: SINGLE/ MARRIED/ DIVORCED/ WIDOWED

Date of Birth: _____/_____/_____

Referring Physician: _____

I herby authorize my insurance to be paid directly to the above facility, realizing that I am responsible to pay non-covered services and I herby authorize the release of pertinent medical information to the insurance carriers.

Signature: _____

Date: _____/_____/_____

MUNSTER OPEN MRI & IMAGING

Patient Questionnaire

Exam being performed _____ Weight _____

Please explain your symptoms in detail _____

_____

HOW and WHEN did this happen? _____

_____

How or where did you first hear about **Munster Open MRI & Imaging**?

family_____friend_____magazine_____newspaper_____physician_____

Other, please explain_____

Have you had any of the following: Please circle **Yes or No**

1. **Yes or No** Surgery in the area being scanned
2. **Yes or No** Cancer or Tumor
3. **Yes or No** Chemotherapy or Radiation Therapy
4. **Yes or No** Allergies
5. **Yes or No** Lung problems
6. **Yes or No** Heart or Blood Pressure problems
7. **Yes or No** Seizures
8. **Yes or No** Kidney Failure or Dialysis

If you have answered **YES** to any of the above questions, please explain:

_____

Yes or No Have you ever had a prior **CT, MRI or X-Ray** of the area being imaged?

If Yes, When? Where? _____

Do you have any questions about your MRI procedure? _____

Patient Signature: _____

Date: _____/_____/_____

MUNSTER OPEN MRI & IMAGING

MRI Patient Screening

Everyone entering the exam room must complete the following safety screening. Certain items can interfere with or be hazardous to you during the study.

Do you have a cardiac pacemaker, pacer wire or implanted defibrillator?	**Yes**	**No**
Other implanted devices (i.e., insulin pump, infusion pump, intrauterine device)?	**Yes**	**No**
Do you have a middle ear implant (i.e., stapes prosthesis, cochlear implant)?	**Yes**	**No**
Do you have any aneurysm clips in the head or neck?	**Yes**	**No**
Have you ever had metal particles in your eyes?	**Yes**	**No**
If yes, have you had an MRI since then? If not, x-rays must be taken before the MRI can be done to ensure there is no metal remaining.	**Yes**	**No**
Do you have artificial heart valves?	**Yes**	**No**
Do you have any type of intravascular coil, filter or stent? (i.e., IVC filter, Palmaz stent, umbrella filter, Swan-Ganz catheter)	**Yes**	**No**
Do you have any shrapnel or other metal in your body? (Including bone or joint pins, plates, screws)	**Yes**	**No**
Have you had surgery within the past 6 weeks?	**Yes**	**No**
Are you claustrophobic? (afraid or bothered by small spaces)	**Yes**	**No**
Are you pregnant or a nursing mother?	**Yes**	**No**
Do you have any body piercings (i.e., nose, lip, tongue, eyebrow, navel, nipple, earrings, etc.)? Tattooed eyeliner?	**Yes**	**No**
Do you have dentures or hearing aides?	**Yes**	**No**
Are you wearing any medicated patches?	**Yes**	**No**

If you answered yes to any of these questions, please offer an explanation.

_____

WARNING: Hearing aides must be removed before entering the procedure room. Please take off all loose jewelry (earrings, necklace, watch and bracelets). Depending on your scan, you may be asked to remove dentures or partial plates.

Patient Signature: _____

Date: _____/_____/_____

MUNSTER OPEN MRI & IMAGING

Notice of Privacy Practice Acknowledgement

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in my care.
Obtain payment from third party payers
Conduct normal healthcare operations such as quality assessments and physician certifications

I understand the Notice of Privacy Practices. I understand that I may contact Munster Open MRI and Imaging at any time to request a current copy of the Notice of Privacy Practices.

I understand that I may request in writing how my private health information is used or disclosed to carry out treatment, payment of health care operations by Munster Open MRI and Imaging.

Patient Name: _____

Signature: _____

Date: _____/_____/_____