WARNING!!!!!!!!!

Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MRI procedure. Please address any concerns prior to entering the MRI room. The magnet is ALWAYS on!

<u>*Remove all metal before entering the MRI exam room including hearing aids, watches, jewelry, hair pins, keys, pocket knives, wallet, phones, beepers, safety pins, nail clippers, coins, credit cards, canes, pens, etc.*</u>

Prestonwood Imaging Center

6957 West Plano Parkway, Suite 1100
Plano, Texas 75093
Office 972.395.7533 Fax 972.395.7536

Name:____________________DOB:_______Age:___Height:_____Weight:____

Please answer ALL questions. Discuss any concerns with technologist.

Have you had any **previous studies** pertaining to your problem in the past 12 months?

_____*XRAYS* *Where/When?*__________________

_____*CT (cat scan)* *Where/When?*__________________

_____*MRI* *Where/When?*__________________

Reason for MRI and/or symptoms?__________________________________

Please list any **surgeries** that you have had:__________________________________

____

Allergies to medications or food? Y/N If yes, what? ________________

History of **Cancer?** Y/N If yes, where/when? ________________

Are you taking any **medications** now? Y/N If yes, which? ________________

Ladies: Are you **pregnant?** Y/N

Are you **breastfeeding?** Y/N

Circle all that apply? Pain Numbness Tingling Weakness Instability
Popping Clicking Locking Swelling Color Change

Please indicate if you have any of the following: Circle (Y)es or (N)o

Surgery to area of examination	Y / N	Medication pump	Y / N
Brain Surgery	Y / N	Artificial heart valve	Y / N
Cardiac Pacemaker	Y / N	Stents, vascular clips	Y / N
Cochlear (ear) implants	Y / N	Artificial limb	Y / N
Aneurysm Clips	Y / N	Shrapnel or gunshot wound	Y / N
Metal in eyes or metal worker	Y / N	Penile implant	Y / N
Neurostimulators (TENS)	Y / N	Metal anywhere else in body	Y / N
Joint replacement	Y / N	Hearing aid (remove)	Y / N
~~Dentures~~	~~Y / N~~	~~Tattoo makeup (eyeliner)~~	~~Y / N~~

I authorize the release by Prestonwood Imaging Center any medical information and/or films necessary to process claims for payment; the release to other physicians or medical facilities as designated by me and/or to obtain previous reports and/or films to aid in our Radiologists interpretation.

Patient's Signature:______________________________

Date:____________________

I authorize direct payment of all medical benefits to Prestonwood Imaging Center.

Patient's Signature:______________________________

Date:____________________

TECHNOLOGIST INITIAL____________________

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MRI Contrast Media Assessment Form

Your physician has scheduled you for an Imaging Study that requires the intravenous injection of a special contrast media containing gadolinium. The purpose of the contrast media is to provide better viewing of the anatomy being examined. This will help the radiologist more accurately interpret the resulting images.

Normally, the use of contrast media is quite safe; however any medical procedure carries with it a slight risk. The risk can range from hives, nausea, asthma, and/or swelling of the airway. Very rarely, approximately 1 in 100,000 may experience a severe reaction including death.

The radiologist and the diagnostic imaging department staff are trained and prepared to quickly respond to these types of reactions with the appropriate treatment. Your doctor has considered these risks before recommending this examination and believes that the diagnostic benefits far outweigh the minimal risks involved. If you have any questions, please be sure to address them with the radiology technologist before this procedure.

Please answer the following questions and sign below:

1. Have you ever had a previous MRI study which required the use of an intravenous contrast material? YES NO

2. Have you ever had a previous contrast media reaction? YES NO
3. If so, please briefly describe your previous contrast media reaction below.

   ____

4. Do you have any kind of allergies including asthma or hay fever? YES NO
5. If so, what are you allergic to? Please list below:
   a. Food: ______________________________
   b. Medications: ______________________________
   c. Environmental: ______________________________

6. Do you have any known kidney disease including hypertension (high blood pressure)? YES NO

7. Do you have diabetes? YES NO

8. Do you have heart disease? YES NO

9. Are you pregnant? If so, what is your due date? ____________ YES NO

I certify that I have read the information provided above and answered the questions to the best of my ability. I understand the information provided and give my consent to proceed with the use of the intravenous gadolinium contrast medium.

Patient's Signature: ______________________________ Date: ______________

TECHNOLOGIST INITIAL ______________

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Plano, Texas 75093
Office 972.395.7533 Fax 972.395.7536

Clinic: 519

FINANCIAL RESPONSIBILITY AGREEMENT

Patient Name: ________________ Date of Birth: ____________ Date of Visit: __________

I understand and agree that I will be financially responsible for any and all charges for services not paid by my insurance for my visits. This includes any medical service or visit, preventative exam or physical, lab testing, x-ray, EKG, and any other screening service or diagnostic testing ordered by the physician or the physician's staff.

I understand and agree that it is my responsibility and not the responsibility of the physician or clinic to know if my insurance will pay for my medical service or visit, preventative exam or physical, lab testing, x-ray, EKG, or any other screening service or diagnostic testing ordered by the physician or the physician's staff.

I understand and agree it is my responsibility to know if the physician or provider I am seeing is a contracted in-network provider recognized by my insurance company or plan. If the physician or provider I am seeing is not recognized by my insurance company or plan, it may result in claims being denied or a higher out of pocket expense to me. I understand this and agree to be financially responsible and make full payment.

I understand and agree that it is my responsibility to know if my PCP (primary care physician) choice has been processed by my insurance company or plan. If I have requested a PCP change that is not processed by my insurance company, it may result in claims being denied. I understand this and agree to be financially responsible and make full payment.

Patient's Signature: ________________________ Date: ______________
(please sign here-Patient or Responsible Party)

Responsible Party Name: ______________________________
(please print name of Responsible Party if different from Patient)

Attention: Prestonwood Patients!!!!!

24-48 Hours after your procedure, your primary care Doctor will receive a report. In order to get your results, you must consult your Doctor. Should you choose to see a Specialist or get a second opinion, you are responsible for calling us 48 hours in advance in order to request your films and report. In order to provide the best service possible to you and your Doctor, we need your cooperation. Please let us know how we may assist you.

THANK YOU

Patient Signature____________________

Date____________________

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X-RAY, CT & MRI Pregnancy Questionnaire for Females Age 10-55 Years

Name: ______________________ Date: ______________________

DOB: ______________ Age: __________

To your knowledge, are you pregnant? YES / NO

If so, how far along are you? ______________
(Also, IF YOU ARE PREGNANT, please notify the technologist and the front desk BEFORE proceeding with your exam!)

If you are NOT pregnant, when was the date of your last menstrual cycle? ______________

Are you presently on some method of birth control? YES / NO

If so, please specify the method: ______________

Have you had a hysterectomy? YES / NO

Have you had a tubal ligation? YES / NO

Are you currently a breast feeding mother? YES / NO

If so, we ask that you do not breastfeed for 48 hours following the administration of ~~intravenous iodinated (containing iodine) contrast material.~~

I have answered the above questions to the best of my ability. I have been informed of the potential risks involved if I am pregnant from the CT and/or MRI technologists. By signing this authorization form, I am giving my consent to proceed with the CT and/or MRI scan that my referring physician has ordered for me today.

Patient's Signature: ______________________ Date: ______________

TECHNOLOGIST INITIAL __________