



A BMC Diagnostics Company

99 El Camino Real
Menlo Park, Ca. 94025
Office (650)327-1121
Fax (650) 327-1122

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT
PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996("HIPAA"), 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 that treatment directly and indirectly.
• Obtain payment from third-party payers.
• Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you or have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address listed above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment of health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Consent for Diagnostic Services:

I have been informed of the reasons for this procedure. Understanding this, I authorize 3T MRI to perform the procedure.

Patient Name: _____ Date of birth: _____ Age: _____

Patient Address: _____
Street address

City State Zip

Phone: (____) _____ SS#: _____ - _____ - _____

Employed by: _____ Occupation: _____

Business address: _____ Business phone: (____) _____
Street address City State Zip

In case of emergency name of nearest relative: _____ Phone: (____) _____

I hereby authorize 3T MRI to obtain any medical information concerning myself/other _____
(State Patient Name and Relationship)

that is pertinent to the interpretation, evaluation and or performance of any radiological procedure provided by 3T MRI.

Assignment of claim:

I hereby authorize 3T MRI to furnish my insurance company all information which said insurance company may request concerning my medical condition. I hereby assign 3T MRI all payments for Medical expenses, to which I am entitled for, related to services provided. I understand I am financially responsible for charges not covered by my insurance.

Financial Agreement:

Private Pay: I, the undersigned, hereby agree, whether signing as agent or as a patient, to be financially responsible to 3T MRI for charges not paid by my insurance. I understand this amount is due upon receipt of invoice.

Insurance Coverage: I certify that the information given to me in applying for payment under government or private insurance is correct. Any portion of charges not paid by my insurance company within 45 days of submission of the claim, regardless of the reason of any delay, will be billed to me and will then be due within 30 days of invoice. I understand that 3T MRI will verify my insurance coverage; but that this does not guarantee payment by my insurance company and I will be responsible for all non-covered charges. I understand that it is my responsibility to determine the coverage limits of my insurance.

I understand a late fee of up to **10%** of the outstanding balance may be charged for late payment on invoiced charges. This is in addition to a charge for reasonable attorney fees, court costs, and collection agency expenses incurred to collect the amount due.

Patient or legally authorized individual signature

Date

Printed name if signed on behalf of the patient

Relationship
(parent, legal guardian)

Technique: _____

Routine: _____

Other: _____

Notes: _____

PLACE LABEL HERE

FOR OFFICE USE ONLY

PATIENT HISTORY & SAFETY SCREENING – Date of injury ___/___/___ Weight _____ Age _____

****THIS IS NEEDED TO ENSURE THAT YOUR DOCTOR HAS RESULTS ON TIME****

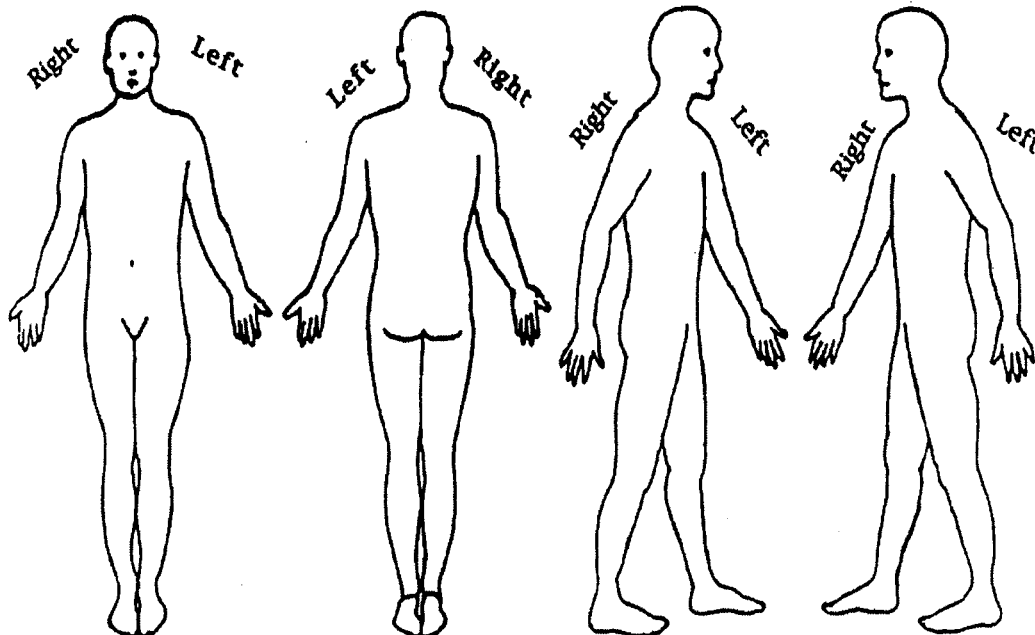
When is your follow up appointment with your doctor? _____

Have you ever had any surgery in the area being scanned? YES, date _____ NO

1. Any history of trauma in the area we are scanning today?
if so, please describe _____
2. Do you personally have a history of cancer? if so, please describe _____
*Any history of skin cancer? if so please mark which ___ melanoma or ___ squamous/basal cell
3. Have you had any of the prior studies related to your current problem?
X-Rays date _____ where _____
CT Scan date _____ where _____
MRI Scan date _____ where _____
5. Are you or is there a possibility you are pregnant? YES NO
6. Are you presently, or have you ever worked as a machinist, metal worker, or in a profession grinding metal? YES NO

Pain Information

Please mark the areas of your body where you feel pain, numbness, tingling or weakness



How long have you had these symptoms? _____

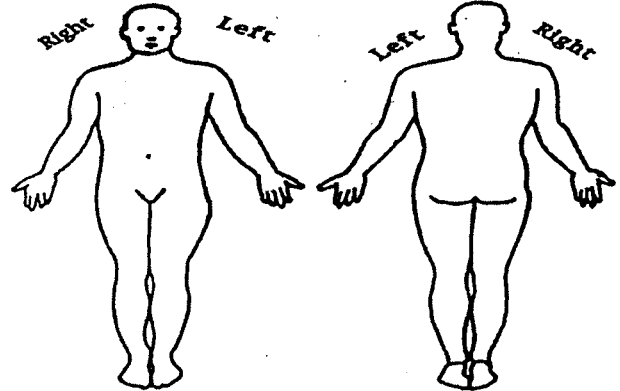


WARNING: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure (i.e., MRI, MR angiography, functional MRI, MR spectroscopy). **Do not enter** the MR system room or MR environment if you have any questions or concern regarding an implant, device, or object. Consult the MRI Technologist or Radiologist **BEFORE** entering the MR system room. The **MR system magnet** is ALWAYS on.

Please indicate if you have any of the following:

- Yes No Aneurysm clip (s)
- Yes No Cardiac pacemaker
- Yes No Implanted cardioverter defibrillator (ICD)
- Yes No Electronic implant or device
- Yes No Magnetically-activated implant or device
- Yes No Neurostimulation system
- Yes No Spinal cord stimulator
- Yes No Internal electrodes or wires
- Yes No Bone growth/bone fusion stimulator
- Yes No Cochlear, orologic, or other ear implant
- Yes No Insulin or other infusion pump
- Yes No Implanted drug infusion device
- Yes No Any type of prosthesis (eye, penile, etc.)
- Yes No Heart valve prosthesis
- Yes No Eyelid spring or wire
- Yes No Artificial or prosthetic limb
- Yes No Metallic stent, filter, or coil
- Yes No Shunt (spinal or intraventricular)
- Yes No Vascular access port and/or catheter
- Yes No Radiation seeds or implants
- Yes No Swan-Ganz or thermodilution catheter
- Yes No Medication patch (Nicotine, Nitroglycerine)
- Yes No Any metallic fragment or foreign body
- Yes No Wire mesh implant
- Yes No Tissue expander (e.g. breast)
- Yes No Surgical staples, clips, or metallic sutures
- Yes No Joint replacement (hip, knee, etc.)
- Yes No Bone/joint pin, screw, nail, wire, plate, etc.
- Yes No IUD, diaphragm, or pessary
- Yes No Dentures or partial plates
- Yes No Tatoo or permanent makeup
- Yes No Body piercing jewelry
- Yes No Hearing aid
(Remove before entering MR system room)
- Yes No Other Implant _____
- Yes No Breathing problem or motion disorder
- Yes No Claustrophobia

Please mark on the figure (s) below the location of any implant or metal inside of or on your body.



IMPORTANT INSTRUCTIONS

Before entering the MR environment or MR system room, you must remove all metallic objects including hearing aids, dentures, partial plates, keys, beeper, cell phone, eyeglasses, hair ins, barrettes, jewelry, body piercing jewelry, watch, safety pins, paperclips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clipper, tools, clothing with metal fasteners, & clothing with metallic threads.

Please consult the MRI Technologist or Radiologist if you have any questions or concern **BEFORE** you enter the MR system room.

I attest that the above information is correct to the best of my knowledge. I read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form and regarding the MRI procedure that I am about to undergo.

Signature of person completing form: _____ Date ____/____/____
Print name

Form Completed by: Patient Relative Nurse _____
Print name Relationship to patient

Form Information Reviewed By: _____
Print Name Signature

- MRI Technologist
- Nurse
- Radiologist
- Other _____