BURLINGAME
Formerly: MRI of Burlingame
1860 El Camino Real, Suite 101
Burlingame, CA 94010
650.552.0700 office
650.552.0704 fax

SAN FRANCISCO
50 Francisco Street, Suite 105
San Francisco, CA 94133
415.433.3535 office
415.433.3536 fax

SAN RAFAEL
Formerly: Bay Area OpenScan MRI
4144 Redwood Highway, Suite B
San Rafael, CA 94903
415.479.9907 office
415.479.9908 fax

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 Bay Area 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 Bay Area 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 Bay Area MRI.

Assignment of claim:
I hereby authorize Bay Area MRI to furnish my insurance company all information which said insurance company may request concerning my medical condition. I hereby assign Bay Area 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 Bay Area 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 Bay Area 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)

Bay Area MRI ☐ ***Burlingame*** ☐ ***San Francisco*** ☐ ***San Rafael*** ☐ ***3T MRI*** *Menlo Atherton*

A BMC Diagnostics Company

Technique:______________________________

PLACE LABEL HERE

Routine:______________________________

Other: ______________________________

Notes: ______________________________

____

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****

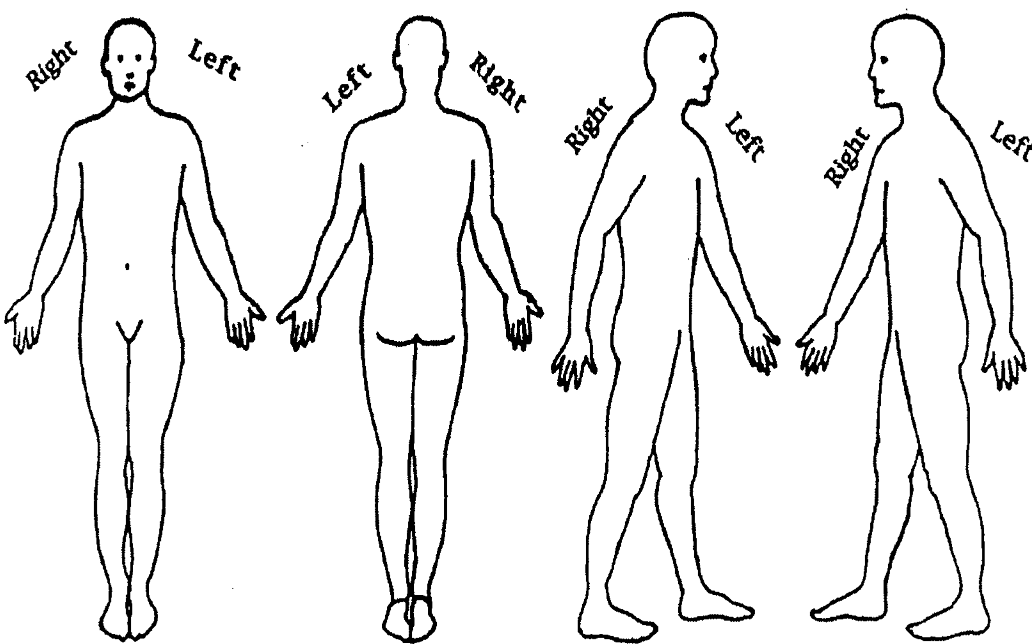
When is your follow up appointment with your doctor? ______________________

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



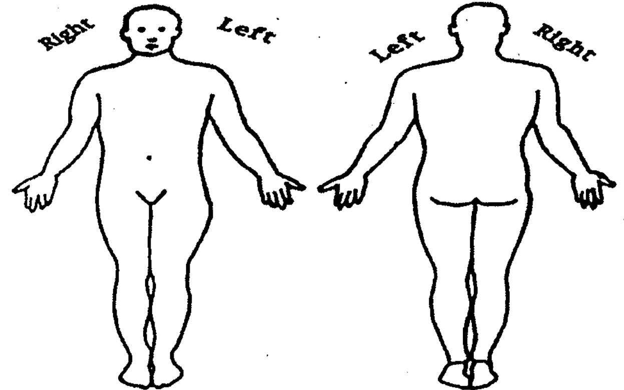
How long have you had these symptoms?_____________

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 Artifical 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.



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 ______________________