ALBANY ADVANCED IMAGING, PLLC
3 ATRIUM DRIVE
ALBANY, NEW YORK 12205

Patient Name: ______________________________ Date: ___/___/___

Address: ____
Street City/State Zip Code

DOB: ___/___/___ Soc. Sec. No.: ____-____-____ Tel.: (____) ____-______

Insurance Guarantor (policyholder): ______________________ DOB: ___/___/___

Address (if different from above): ______________________________

Patient Insurance Waiver and Notice of Responsibility

As a consumer of medical service, you may have an agreement with an insurance carrier to assist with payment of your medical care. Albany Advanced Imaging, P.L.L.C., maintains agreements with various insurance carriers. Should we participate with your insurance carrier, we are happy to bill your insurance provider directly. Your signature on this form today authorizes us to do so. If your insurance carrier (for whatever reason) chooses not to satisfy your bill in full, you understand and accept complete personal responsibility for any payment due.

Some insurance companies require your doctor to obtain approval before imaging is performed. Albany Advanced Imaging, P.L.L.C. is not responsible for obtaining or justifying pre-certification, authorization or approval. Your signature authorizes Albany Advanced Imaging, P.L.L.C. to perform the examinations(s) requested by your doctor. Albany Advanced Imaging, P.L.L.C. is not responsible in any way should your insurance carrier deny payment for your examination.

Initial Here ________________

Receipt of Notice of Privacy Practices ***POSTED ON WALL***

I have been informed of the Notice of Privacy Practices from Albany Advanced Imaging, P.L.L.C. concerning how the use of disclosure of Protected Health Information will be handled by the practice. This notice is posted in the office reception area. I understand I can also receive a copy of this notice.

(Initial here) ________________

Signature: ______________________________ Date: ___/___/___

Your relationship to the patient (if applicable) ______________________

ALBANY ADVANCED IMAGING
3 Atrium Drive, Suite 160 • Albany, New York 12205
518.438.0600 • fax 518.435.0738 • www.albanyimaging.com

Breast MRI Questionnaire

NAME: ______________________ **AGE:**_________ **Sex**: Male Female

Diagnosis (Why are you having this study?)______________________

Have you or are you taking hormone replacements, supplements or birth control pills? ______________

When was the first day of your last menstrual cycle? ______________ Post-Menopausal? Yes No

Have you had a hysterectomy? Yes / No Was it a complete hysterectomy? Yes / No

Do you or have you had breast cancer? Yes / No Which breast? RIGHT / LEFT OR BILATERAL

When were you diagnosed? ______________ Did the tumor spread elsewhere in your body? Yes / No

Where in the body did your tumor spread? (metastasis) ______________________

What type of therapy did you receive to your breast cancer?

	SIDE		DATE
Surgery	Right or Left		__________
Lumpectomy	Right or Left		__________
Mastectomy	Right or Left		__________
Chemotherapy	Right or Left		__________
Radiation Therapy	Right or Left		__________
Hormonal Therapy	Right or Left		__________
Have you taken Tamoxifen/Arimdex	Yes / No	For how long?	__________

Have you had a Breast biopsy? Yes / No Right or Left What facility? __________

Do you have breast implants? Yes / No If so, what type of implant? saline or silicone __________

Do you feel a breast lump or mass? Yes / No If so, where? ______________________

Have you had a breast MRI before? Yes / No If so, what facility? ______________________

When was your last mammogram? ______________ If so, what facility? ______________

Family History: Mother_____ Daughter _____ Sister _____ Grandmother _____ Aunt ______

Are you BRCA1 or BRCA2 gene positive? Yes / No / Don't know

Patient Signature: ______________________ **Date:** __________ **Time:** __________

ALBANY ADVANCED IMAGING
MAGNETIC RESONANCE (MRI) PROCEDURE SCREENING FORM FOR PATIENTS

Date ___/___/___ Name: ____
Last name **First Name** **Middle initial**

WARNING: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR. Do not enter the MR room if you have any question or concern regarding an implant, device or object. Consult the MRI Technologist BEFORE entering the MR system room. The MR system magnet is always on.

Please check "YES" or "NO":

1. Have you had an injury to the eye involving a metallic object or fragment (e.g., metallic slivers, shavings, foreign body, etc.)? ☐ YES ☐ NO
   If yes, please describe: ____
2. Have you ever been injured by a metallic object or foreign body (e.g., BB, bullet, shrapnel, etc.)?.......... ☐ YES ☐ NO
   If yes, please describe: ____
3. Do you have renal (kidney) disease or have a history of renal (kidney) problems?.......... ☐ YES ☐ NO
4. Do you have a history of reaction to a contrast medium or dye used for an MRI, CT, medication or other allergies? .... ☐ YES ☐ NO
   If yes, please describe: ____
5. Do you have a history of asthma or seizures? .... ☐ YES ☐ NO
6. Do you have anemia or any disease(s) that affects your blood? .... ☐ YES ☐ NO
   If yes, please describe: ____
7. Are you pregnant or do you suspect you might be or currently breastfeeding?.......... ☐ YES ☐ NO

Please check "YES" or "NO":

☐ 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/Bladder stimulator**	☐ YES ☐ NO	**Internal electrodes or wires**
☐ YES ☐ NO	Bone growth/bone fusion stimulator	☐ YES ☐ NO	**Cochlear, otologic, or other ear implant**
☐ YES ☐ NO	**Insulin or other infusion pump/transmitter**	☐ YES ☐ NO	**Heart valve prosthesis**
☐ YES ☐ NO	**Any type of prosthesis (eye, penile, etc.)**	☐ YES ☐ NO	Artificial or prosthetic limb
☐ YES ☐ NO	**Eyelid spring or wire**	☐ YES ☐ NO	**Shunt (spinal or intraventricular)**
☐ YES ☐ NO	**Metallic stent, filter, or coil**	☐ YES ☐ NO	Radiation seeds or implants
☐ YES ☐ NO	*Vascular access port, catheter, drug infusion device*	☐ YES ☐ NO	Any metallic fragment or foreign body
☐ YES ☐ NO	Medication patch (Nicotine, Nitroglycerine)	☐ YES ☐ NO	Tissue expander (e.g., breast)
☐ YES ☐ NO	Wire mesh implant	☐ YES ☐ NO	Tattoo or permanent makeup
☐ YES ☐ NO	Bone/joint pin, screw, nail, wire, plate, joint replacement	☐ YES ☐ NO	Hearing aid, body piercing jewelry (remove before entering MR system room)
☐ YES ☐ NO	IUD, diaphragm, or pessary		
☐ YES ☐ NO	Dentures or partial plates		
☐ YES ☐ NO	**Other implant**		

********Bolded items require implant Name, make, model/serial number prior to MRI*******

Patient Weight:_________ **Implant name** __________________ **Make** _______________ **Model/Serial** ____________

⚠

IMPORTANT INSTRUCTIONS

Remove all metallic objects before entering the MR environment or MR system room including hearing aids, beeper, cell phone, keys, eyeglasses, hair pins, barrettes, jewelry (including body piercing jewelry), watch, safety pins, paperclips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clipper, steel-toed boots/shoes, and tools. Loose metallic objects are especially prohibited in the MR system room and MR environment.

Please consult the MRI Technologist or Radiologist if you have any question or concern BEFORE you enter the MR system room.
I attest that the above information is correct to the best of my knowledge. I have read and understand the entire contents of this form and have had the opportunity to ask questions regarding the information on this form.

--- ----------------------------------
Patient or guardian signature Date

Reviewed by: --
□ Technologist □ RN □ Other ________________________________

Prohance (Gadolinium) ______ **ml. volume administered Lot #** _____________ **RAC LAC** __________ **Initials** ____________

Albany
Advanced Imaging
THE RADIOLOGY SPECIALISTS

MR SYMPTOMS SHEET

Patient Name: ___________________________
DOB: ___________

Please **describe your symptoms** (include the **area of pain**, duration and any other relevant information)

____
____
____

Have you had a **recent or past injury** to this area? ________ If yes, please list below.

Recent Injury (within the last 3 months) **Date of Injury**:___________

Describe Injury___________________________________
____
____

Past Injury- Date of Injury ________

Describe Injury ___________________________________
____
____

Have you had any surgery **to this area**? ______ If yes, what type of surgery and when?

____
____
____

Have you had previous radiologic studies (plain films, CT, MR, etc) **of this area**?______
If yes, when and where? ______________________________
Did you bring the films/disc with you? _________________

Do you have any history of cancer, if so, what type?

____
____
____

Signature:___________________________ Date: ___________