

CLIFTON PARK ADVANCED IMAGING, PLLC
648 PLANK RD.
CLIFTON PARK, NEW YORK 12065

Patient Name: _____ Date: ___/___/___

Address: _____
Street City/State Zip Code

DOB: ___/___/___ Tel.: (____) _____ - _____

Insurance Policy Holder (Person): _____ 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) _____

CLIFTON PARK 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":

- | | |
|--|---|
| <input type="checkbox"/> YES <input type="checkbox"/> NO Aneurysm clip(s) | <input type="checkbox"/> YES <input type="checkbox"/> NO Cardiac pacemaker |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Implanted cardioverter defibrillator (ICD) | <input type="checkbox"/> YES <input type="checkbox"/> NO Electronic implant or device |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Magnetically-activated implant or device | <input type="checkbox"/> YES <input type="checkbox"/> NO Neurostimulation system |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Spinal cord/Bladder stimulator | <input type="checkbox"/> YES <input type="checkbox"/> NO Internal electrodes or wires |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Bone growth/bone fusion stimulator | <input type="checkbox"/> YES <input type="checkbox"/> NO Cochlear, otologic, or other ear implant |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Insulin or other infusion pump/transmitter | <input type="checkbox"/> YES <input type="checkbox"/> NO Heart valve prosthesis |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Any type of prosthesis (eye, penile, etc.) | <input type="checkbox"/> YES <input type="checkbox"/> NO Artificial or prosthetic limb |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Eyelid spring or wire | <input type="checkbox"/> YES <input type="checkbox"/> NO Shunt (spinal or intraventricular) |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Metallic stent, filter, or coil | <input type="checkbox"/> YES <input type="checkbox"/> NO Radiation seeds or implants |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Vascular access port, catheter, drug infusion device | <input type="checkbox"/> YES <input type="checkbox"/> NO Any metallic fragment or foreign body |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Medication patch (Nicotine, Nitroglycerine) | <input type="checkbox"/> YES <input type="checkbox"/> NO Tissue expander (e.g., breast) |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Wire mesh implant | <input type="checkbox"/> YES <input type="checkbox"/> NO Tattoo or permanent makeup |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Bone/joint pin, screw, nail, wire, plate, joint replacement | <input type="checkbox"/> YES <input type="checkbox"/> NO Hearing aid, body piercing jewelry (remove before entering MR system room) |
| <input type="checkbox"/> YES <input type="checkbox"/> NO IUD, diaphragm, or pessary | |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Dentures or partial plates | |
| <input type="checkbox"/> YES <input type="checkbox"/> 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 _____

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: _____