Patient Insurance Information

Patient Info

Name:

Main Address:

City, ST Zip:

Phone 1/Type:

Phone 2/Type:

Birth Date: Gender M ☐ F ☐

SSN:

Marital Status:

Guarantor Info

Name:

City, ST Zip:

Phone 1/Type:

Phone 2/Type:

Birth Date: SSN: Gender M ☐ F ☐

Pat Rel to Guar:

Emergency Contact 1:

Rel to Patient:

Phone 1/Type:

Phone 2/Type:

Emergency Contact 1:

Rel to Patient:

Phone 1/Type:

Phone 2/Type:

Primary Insurance

Plan Name:

Address:

City, ST Zip:

Phone:

ID #:

Group #:

Group Name / Employer:

Insured's Name:

Address:

City, ST Zip:

Phone 1/Type:

Insured SSN:

Birth Date: Gender M ☐ F ☐

Pat Rel to IP

Secondary Insurance

Plan Name:

Address:

City, ST Zip:

Phone:

ID #:

Group #:

Group Name / Employer:

Insured's Name:

Address:

City, ST Zip:

Phone 1/Type:

Insured SSN:

Birth Date: Gender M ☐ F ☐

Pat Rel to IP:

I, the insured, hereby authorize **Liv Open MRI** to furnish information regarding my examination to my insurance carrier(s), adjuster(s), attorney(ies), physician(s). I hereby assign to **Liv Open MRI** all payments for medical services rendered not to exceed the total charge for said services. I understand that Medicare and/or my insurance carrier(s) may not pay for these services, even though pre-authorization may have been obtained from said insurance carrier(s)

I also understand that I am ultimately responsible for any and all medical procedure charges as well as late charges.

If my insurance policy(ies) prohibit(s) direct payment to a doctor or medical facility, I hereby instruct the insurance carrier(s) to write a reimbursement check payable to me (the insured) and mail it to **Liv Open MRI**. This payment will be for professional and/or medical expense benefits allowable and otherwise payable to me (the insured) under the current insurance policy(ies) as payment toward the total charges for said services rendered; this is a direct assignment of my (the insured) rights and benefits outlined in my (the insured) insurance policy(ies). This payment will not exceed my indebtedness to the assignee (**Liv Open MRI**).

In addition, I (the insured) agree to pay, in a reasonable manner, any balance of technical and/or professional service(s) charges over and above my (the insured) insurance reimbursement (not to exceed the contracted rate) to the assignee **Liv Open MRI**. I authorize **Liv Open MRI** to initiate a complaint, on my behalf, for any reason, to the Insurance commissioner of this state.

A photocopy of this document is as valid as the original. I have received a patient information brochure and answers to my questions are satisfied.

I certify that the above information is complete and accurate. I understand that if I have provided incomplete or inaccurate information, I may be financially responsible for charges incurred from services rendered.

Signature of the Insured or Proper Authority **Date**

X044SS-E

MRI - Part A

Factors such as weight, body shape and scan type may determine if scan can be performed.

Last Name ____________

First Name ____________

Date of Birth ____________ Date ____________

Height: ____________ Weight: ____________ lbs./kg.

Patient safety is our primary concern. The MRI room contains a very strong magnet and is ALWAYS on. Before you are allowed to enter the MRI room, we must know if you have any metal in or on your body. You MUST remove all metallic objects including cell phone, keys, watches, hair pins, pocket knives, lighters, bank cards, purses, wallets, jewelry, etc. Hearing aids must be removed immediately before entering the MRI room. Failure to remove such items can result in serious damage to those items and/or injury to yourself and others. Please answer the following questions carefully.

I have read and understand the above information, and have removed all metal..... ☐ Yes ☐ No

Medical/Dental Procedures with sedation in the past 24 hours?..... ☐ Yes ☐ No

*** Small Bowel Endoscopy Capsule..... ☐ Yes ☐ No

*** Implanted Cardiac Defibrillator..... ☐ Yes ☐ No
(past or present)

***LVAD Device (Heart Pump)..... ☐ Yes ☐ No

***Breast Tissue Expanders..... ☐ Yes ☐ No

**Existing Pacemaker or Pacemaker wires ☐ Yes ☐ No

**Pregnant..... ☐ Yes ☐ No
Last Menstrual Period ____________

*Implanted Neurostimulator..... ☐ Yes ☐ No

*Artificial Heart Valves/Heart Stents..... ☐ Yes ☐ No
Date: ____________ Make: ____________
Model: ____________

*Surgical/Vascular Clips/Grafts/Stents..... ☐ Yes ☐ No
Type: ____________

*Aneurysm Clips..... ☐ Yes ☐ No

*Recent colonoscopy or digestive system procedure involving surgical clips..... ☐ Yes ☐ No

*Medication Pump..... ☐ Yes ☐ No

*External TENS Unit..... ☐ Yes ☐ No

*Metallic Foreign Body (Gun shot wounds, retinal buckle, etc.)..... ☐ Yes ☐ No

*Eye injury involving Metal..... ☐ Yes ☐ No

*Prior Ear, Eye or Brain Surgery..... ☐ Yes ☐ No

*Catheter, Drainage Tube, Temp Monitor..... ☐ Yes ☐ No

Hearing Aids..... ☐ Yes ☐ No

Dri Weave, Dri Fit or Wicking Clothing..... ☐ Yes ☐ No

I have answered the questions above accurately.

Medication Skin Patches..... ☐ Yes ☐ No

History of Cancer..... ☐ Yes ☐ No
If yes, what type? ____________

Joint Replacement/Joint Implants..... ☐ Yes ☐ No

Orthopedic or Prosthetic Devices..... ☐ Yes ☐ No

Vena Cava Umbrella Filter..... ☐ Yes ☐ No

Hair Extensions/Hair Pieces/Wig..... ☐ Yes ☐ No

Braces, Oral Springs, Removable Dental Work..... ☐ Yes ☐ No

Glitter/Permanent Eye Makeup..... ☐ Yes ☐ No

Anything Held with Magnets or Pins..... ☐ Yes ☐ No

Tattoos and/or Body Piercing..... ☐ Yes ☐ No

Claustrophobic?..... ☐ Yes ☐ No

Iron Deficiency being treated w/ Feraheme ☐ Yes ☐ No

History of Epilepsy (seizures)..... ☐ Yes ☐ No

History of Diarrhea in past 2-3 days..... ☐ Yes ☐ No

Any falls within past 30 days?..... ☐ Yes ☐ No
If yes, when: ____________

Anything in or on your body that you weren't born with?
☐ Yes ☐ No If not listed above, notify the Technologist.

Did you pre-medicate for this exam?..... ☐ Yes ☐ No

Do you have a driver?..... ☐ N/A ☐ Yes ☐ No

Please list all past surgeries and their dates:

____

____

Any previous imaging study related to the reason for today's exam?..... ☐ Yes ☐ No
Type of Exam ____________
Facility ____________
Date ____________

Signature of Patient: ____________ Date: ____________ Time: ____________
(Parent or Guardian if patient is a Minor or Incapacitated) Relationship: ____________

MRI CANNOT be performed if "Yes" is answered to triple asterisked (***) questions. Double asterisked (**) require a signed informed consent. Single asterisked (*) may require further discussion between the Radiologist & Technologist. Document any verbal approvals/instructions on Part B.

*I have reviewed each response with the patient or their legal guardian, power of attorney, next of kin, etc. and **PERFORMED CLINICAL PAUSE #1.***

Technologist's Signature: ____________ Date: ____________

PATIENT CLINICAL HISTORY QUESTIONNAIRE

Patient (Last, First Middle) ____ Sex ____ DOB ____ Age ____

Do you have a follow up appointment with referring DR: ____ ☐Yes ☐No Date: ____

Females: Pregnant? ☐Yes ☐No Breastfeeding? ☐Yes ☐No Last Menstrual Period? ____

Describe Your Symptoms (including pain) and How Long You Have Had Them:

____

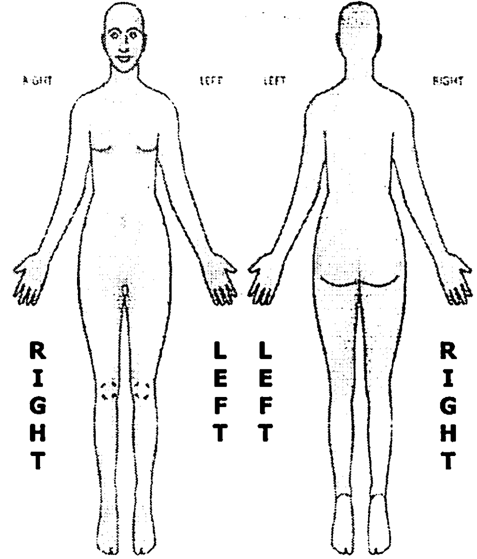
____

____

____

Symptoms Related to Injury? ☐Yes ☐No Auto Accident? ____ Date: ____

Please shade in affected areas



Anatomy	***Location***		***Sensation***			
Neck	☐Right	☐Left	☐Pain	☐Tingling	☐Weakness	☐Numbness
Back	☐Right	☐Left	☐Pain	☐Tingling	☐Weakness	☐Numbness
Arm	Left		☐Pain	☐Tingling	☐Weakness	☐Numbness
Arm	Right		☐Pain	☐Tingling	☐Weakness	☐Numbness
Leg	Left		☐Pain	☐Tingling	☐Weakness	☐Numbness
Leg	Right		☐Pain	☐Tingling	☐Weakness	☐Numbness

Have You Had Surgery on Area Being Scanned? ☐Yes ☐No

If Yes, When: ____

Symptoms Since Surgery: ☐Better ☐Worse ☐Same ☐Different

Describe What Was Performed:

____

____

____

Have You Had Radiation Therapy on Area Being Scanned? ☐Yes ☐No

Have You Been Taking Oral Medications Prescribed by a Doctor? ☐Yes ☐No

If Yes, ☐More Than 6 Weeks Ago ☐Less Than 6 Weeks Ago

Have You Had Chiropractic Therapy? ☐Yes ☐No

If Yes, ☐More Than 6 Weeks Ago ☐Less Than 6 Weeks Ago

Have You Had Acupuncture Therapy? ☐Yes ☐No

If Yes, ☐More Than 6 Weeks Ago ☐Less Than 6 Weeks Ago

Have You Had Physical Therapy? ☐Yes ☐No

If Yes, ☐More Than 6 Weeks Ago ☐Less Than 6 Weeks Ago

Please check the corresponding box if you have or have had any of the following medical conditions.

☐Asthma	☐Blurred Vision	☐Multiple Myeloma	☐Pancreas Problems
☐Bronchitis	☐Dizziness	☐Chemotherapy	☐Thyroid Problems
☐Bell's Palsy	☐Vertigo	☐Gallbladder Problems	☐Diabetes
☐Head Trauma	☐Buzzing Sound	☐Heart Problems	☐High Blood Pressure
☐Head Surgery	☐Ringing Sound	☐Kidney Problems	☐Bleeding Disorder
☐Headaches	☐Hearing Loss	☐Liver Problems	☐Prostate Problems
☐TMJ Problems/Surgery	☐Cancer - Type ____	☐Lung Problems	☐Hysterectomy

Previous Imaging on Area Being Scanned:

☐X-Rays	Date: ____	Facility: ____
☐CT Scan	Date: ____	Facility: ____
☐MRI Scan	Date: ____	Facility: ____
☐Ultrasound	Date: ____	Facility: ____
☐Nuclear Medicine	Date: ____	Facility: ____
☐Therapeutic Injection	Date: ____	Facility: ____
☐Arthrogram	Date: ____	Facility: ____

PLEASE COMPLETE ALL

Acknowledgement of Receipt of Notice of Privacy Practices

NOTICE OF PRIVACY PRACTICES:
Acknowledgment of Receipt

ACKNOWLEDGMENT OF RECEIPT

By signing this form, you acknowledge receipt of the "Notice of Privacy Practices" of LIV Open MRI Our "Notice of Privacy Practices" provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our "Notice of Privacy Practices" is subject to change. If we change our notice, you may obtain a copy of the revised notice by accessing our website; or contacting our Privacy Officer at the address noted above.

If you have any questions about our "Notice of Privacy Practices," please contact our Privacy Officer.

I acknowledge receipt of the "Notice of Privacy Practices" of LIV Open MRI

Date:______________________________ Time:___________________________AM/PM

Signature:____
(patient/legal representative)

If signed by someone other than patient, indicate relationship:

Print Name:_______________________________

Relationship:______________________________

LIV Open MRI

PATIENT CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT OPERATIONS

I, ______________________________, understand that as a part of my healthcare, LIV Open MRI originates, maintains paper and/or electric records describing my health history, symptoms, examination and test result, diagnoses, and any plans for future care or treatment. I understand that this information serves as:

-A basis for planning my care and treatment
-A means of communication among the many health professionals who contribute to my care
-A source of information for applying my diagnosis and surgical information to my bill
-A means by which a third-party payer can verify that services were actually provided, and
-A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I acknowledge that a copy of LIV Open MRI, Notice of Privacy Practices was posted in a clear and prominent place here I was able to read the Notice of Privacy Practices. I know that I could request a copy and take it with me. I understand that I have the following rights and privileges:

-The right to review the notice prior to signing this consent
-The right to object to the use of my health information for directory purposes, and
-The right to request restrictions as to how my health information may be used to disclosed to carry out treatment, payment, or health care options.

I understand that LIV Open MRI is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 if the Code of Federal Regulations.

I further understand that LIV Open MRI reserves the right to change its notice and practices, in accordance with section 164.520 of The Code of Regulations. Should LIV Open MRI, change its notice, it will send me a copy of any revised notice to the address I have provided (whether U.S. mail or, if I agree, e-mail).

I wish to have the following restriction with regard to the use or disclosure of my health information:

I understand that as part of this organization's treatment, payment or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such a disclosure for these uses, including disclosures via fax.

I fully understand and accept the terms of this consent.

Patient Signature____Date____________________

The following only applies if a restriction is added by patient:

LIV Open MRI Imaging accepts restriction

____
Privacy officer Date

Does not accept restriction

____
___ Privacy Officer Date

FOR OFFICE USE ONLY
{}Consent received by ________On______ {}Consent refused by patient, and treatment as permitted

ALLIANCE RADIOLOGY

OUT-PATIENT FALL RISK ASSESSMENT

PATIENT NAME: ______________________ DATE: ____________

DATE OF BIRTH: ____________ SITE NAME: Livonia Open

INTERVIEWER NAME: ______________________ CUSTOMER NUMBER: 23303

Patient: **The following questions are intended to identify patients who may be at risk of falling and to help avoid potential injury. This procedure has been implemented to ensure your safety and to enable us to provide you with the best possible patient care.**
Please circle the appropriate answer to each question below. Our staff will go over these questions with you prior to your examination to address any questions or concerns you may have.

Question		
1. Have you fallen recently (within the last 3 months)?	YES	NO
2. Do you use a cane, walker or other device to help you walk?	YES	NO
3. Do you require assistance to stand up?	YES	NO
4. Have you taken any medications today for anxiety or to relax you? If yes, what medication? ____________ Dosage ________ Time ________	YES	NO
5. Are you dizzy, lightheaded, weak in your legs or unable to see or hear clearly?	YES	NO

Team Member: **If the patient, patient's family member or caregiver answers "yes" to any of the above questions, transport the patient via wheelchair to the imaging system or exam/treatment room.**
All patients must be assessed for falls risk prior to transporting patients from the waiting area, however, the top portion of this document must be completed and retained in the patient's medical record whenever a mobile unit's lift or roll/slide door is inoperable and the unit's stairs must be utilized. The entire form must be completed, signed and retained in the patient's medical record whenever a patient refuses a wheelchair.

RELEASE OF LIABILITY

Notwithstanding the evaluated risk of fall and Alliance's offer/recommendation to use a wheelchair for transport to/from the imaging system or exam/treatment room, I decline the use of a wheelchair. By declining the use of wheelchair for transport to/from the imaging system or exam/treatment room, I agree, acknowledge and assume all inherent risk including but not limited to the risk of falling, personal injury, damage to personal property, or otherwise. I, on behalf of myself, heirs and/or representatives, do hereby waive and agree to release and hold harmless Alliance HealthCare Services, Inc., its officers, agents, subsidiaries and employees from any and all liability for any damage, claim or injury to myself or my property or otherwise.

PATIENT SIGNATURE: ______________________________

______________________________ ____________________
WITNESS SIGNATURE: TITLE

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