LIV Open MRI

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**

MRI Part A - WHOLESALE

Height _____ Weight _____ lbs/kgs

Last Name: _____

First Name: _____

DOB: _____ Date: _____

The MRI room contains a very strong magnet and is ALWAYS on. You MUST remove all metallic objects. 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.

Medical/Dental procedures in the past 24 hours?	☐ Yes ☐ No
LVAD heart pump, pacemaker or pacer wires, defibrillator?	☐ Yes ☐ No
Implanted neurostimulator or TENS unit?	☐ Yes ☐ No
Medication injection device (OnPro) or pump?	☐ Yes ☐ No
Artificial heart valves/stents or aneurysm/vascular clips/grafts/shunts?	☐ Yes ☐ No
Breast tissue expander, metallic foreign body, bullet/shrapnel or any eye injury involving metal?	☐ Yes ☐ No
Small bowel endoscopy capsule or Vena Cava umbrella filter?	☐ Yes ☐ No
Recent colonoscopy or digestive system procedure involving surgical clips?	☐ Yes ☐ No
Catheter- drainage tube or temperature monitor?	☐ Yes ☐ No
Prior ear, eye or brain surgery?	☐ Yes ☐ No
List previous surgeries and their dates: _____	
Hearing aids or Medication skin patches?	☐ Yes ☐ No
Pregnant? LMP: _____	☐ Yes ☐ No
Joint Replacement or orthopedic/prosthetic device?	☐ Yes ☐ No
History of Cancer? If yes, what type _____	☐ Yes ☐ No
Hair extensions/wig, braces, oral springs, removable dental work or anything held with magnets or pins?	☐ Yes ☐ No
Tattoos/Body Piercings, Glitter/permanent makeup?	☐ Yes ☐ No
DriWeave, Dri Fit or wicking clothing?	☐ Yes ☐ No
Iron deficiency being treated with Feraheme?	☐ Yes ☐ No
History of seizures or any recent falls? If yes, when? _____	☐ Yes ☐ No
Diarrhea in past 2-3 days?	☐ Yes ☐ No
Claustrophobia?	☐ Yes ☐ No
Anything in or on your body that you weren't born with?	☐ Yes ☐ No

GENERAL CONSENT/ACKNOWLEDGEMENT

I consent to the ordered exam. I understand that I have the right to refuse or stop the exam at any time and I have the right to ask questions and discuss my concerns.

I have read the screening information and answered the above safety questions accurately, and I understand I MUST REMOVE ALL METAL prior to my MRI examination.

I acknowledge receipt of the FDA GBCA Medication Guide (if contrast is to be administered).

I have read and I understand, acknowledge and agree to the content of this General Consent form and have had my questions answered. I give my consent to receive electronic communications and survey invitations if applicable.

Patient Signature: _____ Date: _____ Time: _____

(Parent or Guardian if patient is a Minor or Incapacitated) Relationship: _____

PATIENT CLINICAL HISTORY QUESTIONNAIRE

LIV Open MRI

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:

_____

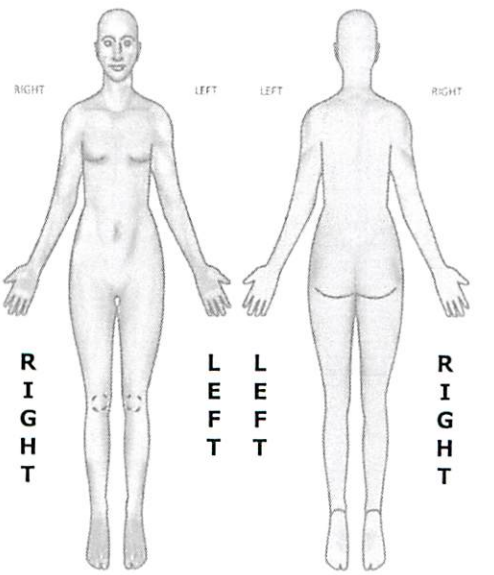
_____

_____

_____

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