ASHLEY RIDGE IMAGING CENTER

Patient's Full Name: ____
(Last) (Suffix) (First) (MI)

Single ☐ Married ☐ Divorced ☐ Widowed ☐ Date of Birth________________ SS#________________

Race: American Indian☐ Asian☐ Black☐ Caucasian☐ Hispanic☐ Language: English ☐ Other____________

Mailing Address______________________________ Physical Address______________________

City______________________________ State________ ZIP____________ Male ☐ Female☐

Home Phone______________ **Work** Phone______________ **Cell** Phone ____________ Email______________
☐ I give my permission to be contacted by Email

Employer____________________ **Address**______________________________________

Emergency Contact (Outside the home) Name:________________ Relationship: __________ Phone__________

How did you hear about Ashley Ridge? ☐ **Physician** ☐ **Friend** ☐ **Previous Appointment Here**
☐ **Newspaper** ☐ **Magazine** ☐ **Radio** ☐ **Other** ______________

Responsible Party ______________________________________ Relationship________________

Address______________________________ City________________ State______ ZIP__________

Date of Birth________________ **SS#**____________________________ Male ☐ Female☐

Employer______________________________ Work Phone________________

Primary Insurance ________________________ Address ____________ ________________

Member Name________________________ Policy #______________________ Group #__________

Member Date of Birth____________ SSN:______________ Employer ________________________

Secondary Insurance ________________________ Address ____________ ________________

Member Name________________________ Policy #______________________ Group #__________

Member Date of Birth____________ SSN:______________ Employer ________________________

Referred By ______________________________

Is this visit related to an injury? Yes ☐ No ☐ Date of Injury__________ Place of Injury ________________

Workers Comp Carrier:____________________ Adjuster:__________________ Claim#______________

Is this visit subject to payment for a Liability Claim? ☐ Yes ☐ No Carrier: ______________________________

I authorize Ashley Ridge Imaging Center to file my insurance and I request that payment of health insurance benefits and 3rd Party Payor benefits be made on my behalf to Ashley Ridge Imaging Center for any services furnished me. I authorize any holder of medical information to release to my health insurance carrier, the health care financing administration and its agents or any other 3rd party payor any information needed to determine these benefits or benefits payable for related services. I understand that I may purchase a copy of my MRI films. Ashley Ridge Imaging Center utilizes Diagnostic Imaging Associates and Radiology Imaging Associates for interpretation of MRI scans. I understand I will receive a separate bill for the interpretation of my exam.

SIGNATURE______________________________________ DATE ________________

Ashley Ridge Imaging Center
MRI PROCEDURE SCREENING FORM

Date ____/____/____

Name ____Age ____ Height ____ Weight _____

Date of Birth _____/______/______ ☐ Male ☐ Female

1. Please list all surgeries you have had: ____

   ____

2. Have you had any previous MRI's, CT's, ANGIOGRAMS, OR X-RAYS of the area that will be scanned today? ____

3. Have you experienced any problem related to a previous MRI examination or MRA procedure?

   ☐ No ☐ Yes

   If yes, please describe: ____

4. Have you had an injury to the eye involving a metallic object or fragment (e.g., metallic slivers, shavings, foreign body, etc.)? ☐ No ☐ Yes

   If yes, please describe: ____

5. Have you ever been injured by a metallic object or foreign body (e.g., BB, bullet, shrapnel, etc.)? ☐ No ☐ Yes

   If yes, please describe: ____

6. Are you allergic to any medication? ☐ No ☐ Yes

   If yes, please list: ____

FOR FEMALE PATIENTS:

7. Are you pregnant or experiencing a late menstrual period? ☐ No ☐ Yes

8. Are you currently breastfeeding? ☐ No ☐ Yes

   If yes, and contrast is given, milk must be expressed and discarded for at least 24 hours.

   Please review breast feeding information sheet.

Patient/Guardian Signature ___________________________________ Date ____________________

Technologist Notes: ____

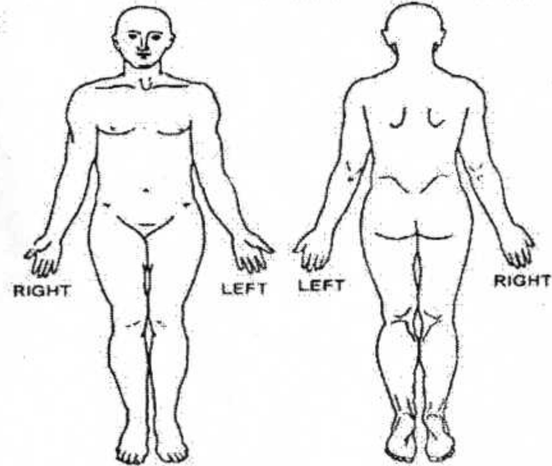
____

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 question 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, otologic, 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 Artificial 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 Tattoo 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.



IMPORTANT INSTRUCTIONS

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 pins, 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 question or concern BEFORE you enter the MR system room.

NOTE: You may be advised or required to wear earplugs or other hearing protection during the MR procedure to prevent possible problems or hazards related to acoustic noise.

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 MR procedure that I am about to undergo.

Signature of Person Completing Form: ______________________________ Date ____/____/____
Signature

Form Completed By: ☐ Patient ☐ Relative ☐ Nurse ______________________________ ____________________
Print name — Relationship to patient

Form Information Reviewed By: ______________________________ ______________________________
Print name — Signature

☐ MRI Technologist ☐ Nurse ☐ Radiologist ☐ Other ____________________

Ashley Ridge Imaging Center
Consent for MRI and Contrast

Patient Name: ______________________________ Date: ______________

MRI EXAMINATION SCHEDULED: ____

Your physician has scheduled you for an MRI examination. If your MRI does not require an injection of contrast media, there are very few risks associated with your examination. The MRI scanner produces a constant strong magnetic field, so if you have any tattoos, metal implants, and/or clips within or on your body please inform the technologist. Metal earrings, metal body piercings, and necklaces must be removed prior to the study. Exposure to MRI scanning might be harmful to a pregnant female or an unborn child. Although there are no established guidelines at this time about MR and pregnancy, you should be informed that there is a possibility of a yet undiscovered pregnancy related risk. MRI scanning produces a loud tone that can cause damage to the inner ear if appropriate sound protection is not used. Earplugs or close fitting headphones will be provided to protect your ears.

IF your physician has ordered an MRI requiring an injection of contrast media into your bloodstream or if our radiologist determined that your procedure would be more beneficial with contrast, there is information we want to make you aware of in addition to the information provided above. The IV contrast media used is "gadolinium". It is a water based contrast and is not iodine. It is considered quite safe; however, any injection carries some risk, including injury to a nerve, artery or vein, infection or reaction to the contrast media being injected. Occasionally, a patient will have a mild allergic reaction to the IV contrast media and develop wheezing, swelling around the eyes, sneezing, itching of the skin or hives. Contrast media may also cause nausea, headaches and dizziness that last a few minutes. Uncommonly, a severe life threatening reaction can occur such as shortness of breath, shock, convulsions, renal failure, and a fall in blood pressure. The physicians of the imaging center are trained to treat these reactions. Very rarely, death has occurred related to IV contrast administration. The risk of such a severe consequence is similar to that of any medication. Recent studies are showing that gadolinium could have an adverse effect on patients that have renal insufficiency or who are in end stage renal disease causing a life threatening disease called Nephrogenic Systemic Fibrosis. If you have renal insufficiency or have been diagnosed with End Stage Renal Disease, please inform the technician. Please alert us if you feel any pain, unusual sensation or any of the side effects described above.

Please review the following list of questions and circle, "yes" or "no" to the questions.

Question			Question		
Do you have a history of kidney disease Or End Stage Renal Disease?	Yes	No	Do you have asthma or any respiratory disease?	Yes	No
Do you have diabetes?	Yes	No	Do you have anemia or sickle cell anemia?	Yes	No
Are you on Dialysis?	Yes	No	Are you a hepatic (liver) transplant recipient, prior transplant of any kind, or are on a transplant list?	Yes	No
Are you pregnant or breastfeeding?	Yes	No	Have you had recent vascular surgery or venous/vascular thrombosis?	Yes	No
Do you have hypertension (High Blood Pressure)	Yes	No	Age > 60	Yes	No
Have you ever had an MRI with contrast material injected into your veins?	Yes	No	History of seizures	Yes	No
If yes, did you experience any problems?	Yes	No			

Your physician has considered the risks listed above before recommending this procedure and he/she believes that the diagnostic benefits far outweigh the risk involved. The purpose of this form is to inform of the procedure and most of its possible side effects and complications.

I hereby state that I have read and understand the information provided above. All questions about the procedure(s) for which I am scheduled have been answered in a satisfactory manner and all blanks were filled in prior to my signature. If I am scheduled for a contrast study I also consent to bloodwork being drawn by Ashley Ridge Imaging Center to obtain a creatnine level. I further understand that it is possible to perform this procedure without a contrast agent, but that such procedure may not provide as much information to my physician as the contrast study. Your signature below is indication that you have read and understand the information provided herein and your signature represents authorization for the MRI examination listed above. Your signature is considered necessary because of the possible complications explained above.

______________________ ______________________ __________

(PrintPatient Name) *(Signature)* *(Date)*

____

(Guardian Signature if applicable)

Ashley Ridge Imaging Center
463 Ashley Ridge Boulevard, Suite 200
Shreveport, LA 71106

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS

I consent to the use or disclosure of my protected health information by Ashley Ridge Imaging Center for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Ashley Ridge Imaging Center. I understand that diagnosis or treatment of me by Ashley Ridge Imaging Center may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Ashley Ridge Imaging Center is not required to agree to the restrictions that I may request. However, if Ashley Ridge Imaging Center agrees to a restriction that I request, the restriction is binding. I have the right to revoke this consent, in writing, at any time, except to the extent that Ashley Ridge Imaging Center has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Ashley Ridge Imaging Center's Notice of Privacy Practices prior to signing this document. Ashley Ridge Imaging Center's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Ashley Ridge Imaging Center. The Notice of Privacy Practices for Ashley Ridge Imaging Center is also provided in the patient waiting area. This Notice of Privacy Practices also describes my rights and Ashley Ridge Imaging Center's duties with respect to my protected health information.

Ashley Ridge Imaging Center reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

The Health Insurance Portability Act of 1996 (HIPAA) grants you the right to designate one or more individuals to act on your behalf regarding the protection of health information that pertains to you. You may designate an individual to be your personal representative below. This person shall be given all of the privileges that would belong to you regarding your health information. Your designation can be revoked at any time by signing a revocation and delivering it to Ashley Ridge Imaging Center. However, any revocation will not apply to the extent that persons authorized to use or disclose the health information have already acted in reliance on your previous designation.

______________________________ ______________________________
Name of Patient (please print) **Name of Designated Personal Representative**

______________________________ ______________________________
Signature of Patient **Relationship of Personal Representative to you**

____
Date

REVOCATION SECTION: I hereby revoke my designation of a personal representative.

______________________________ ______________________________
Signature of Patient **Date**

ASHLEY RIDGE IMAGING CENTER
Assignment of Benefits / Financial Policy

_______________________________ DOB:________________

Patient Name (Please Print)

____

Responsible Party (Please Print)

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YOU WILL RECEIVE A SEPARATE BILL FROM RADIOLOGY IMAGING ASSOCIATES or DIAGNOSTIC IMAGING ASSOCIATES FOR THE READING OF YOUR TEST

_______________________ _______________________

Date Signature of Responsible Party

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I authorize payment of medical benefits under any insurance policy(ies) or other settlement, if any, to Ashley Ridge Imaging Center for the technical component of my test and to the radiology group for the professional reading of my test.

I agree to pay Ashley Ridge Imaging Center for all charges in excess of the amounts paid by my insurance policy(ies). I understand it is my responsibility to determine whether your services are covered by my insurance policy(ies) and to verify preauthorization requirements. Your insurance policy is a contract between you and your insurance company and the filing of insurance forms does not constitute payment of any portion of the bill.

All applicable co-pays, deductibles and coinsurance amounts are due at the time of service. As a courtesy to our patients, we file insurance claims for you.

I agree to pay Ashley Ridge Imaging Center for copayments, deductibles or charges for service which are not covered under my insurance contract. If this is a liability claim, I understand that I am fully responsible for payment of this claim.

_____ All patient balances over 60 days past due will accrue interest at a rate of 9% APR.
Initial

_____ If your account has to be forwarded to a collection agency you will be assessed collection fees in the amount of 25% of the balance owed.
Initial

_____ A fee of $25 will be charged for all checks returned to us as unpaid by your bank.
Initial

_______________________ _______________________

Date Signature of Patient

_______________________ _______________________

Date Signature of Responsible Party