PATIENT INTAKE FORM

DFW OPEN MRI, L.P.

HAVE YOU BEEN HERE BEFORE? YES NO

STUDY: ________________________________
DATE: ______________________

LAST NAME: _____________________________________
FIRST NAME: _____________________________________
ADDRESS: ____
APARTMENT NUMBER#______________________________
CITY: ________________ STATE: ______ZIP: __________
DATE OF BIRTH: __________________________________
AGE: ___________ DATE OF INJURY: ________________
HEIGHT: _____________ WEIGHT: __________________
□ MALE □ FEMALE

REFERRING PHYSICIAN: ________________

CASE TYPE: □ WORK COMP
□ MVA-L O P □ INSURANCE □ CASH
HOME PHONE: (_____)-______-_________
CELL PHONE: (_____)-______-________
SS# _________-________-___________
SPOUSE OR PARENT OR SELF: __________

EMERGENCY CONTACT NAME AND PHONE # ____
E-MAIL ADDRESS: ____

****

INSURANCE COMPANY AND / OR ATTORNEY'S NAME

INSURANCE NAME: ______________________________
ADDRESS: ____________________________________
CITY: ______________ STATE: _____ ZIP: __________
PHONE: (_____)-________-__________
EMPLOYER: __________________________________
ADDRESS: _______________________ STE: ___________
CITY: ________________ STATE: _____ ZIP: __________
PHONE NUMBER _________________________________

ATTORNEY NAME: ____________________
PHONE #: ______________________________
FAX: __________________________________
CLAIM #: ______________________________
POLICY #: _____________________________
W/C PRE-AUTH #: _______________________

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WHAT IS THE REASON YOU WENT TO SEE A DOCTOR? (EXPLAIN WHERE YOUR PAIN IS AND WHICH SIDE AND IF DIZZINESS, NUMBNESS, ECT.) ____

____

HAVE YOU HAD PREVIOUS STUDIES WITHIN THE LAST 12 MONTHS? YES NO
FACILITY NAME: __________________________ TYPE OF MRI: ________________________________
CT: ____ X-RAY: _____________________________________
PREVIOUS SURGERIES: ____

****

CERTAIN CONDITIONS MAY PREVENT YOU FROM HAVING AN MRI EXAM.
PLEASE READ QUESTIONS AND CIRCLE YOUR ANSWER.

DO YOU:

Have a cardiac pacemaker?	Yes or No	Are you claustrophobic?	Yes or No
Have a history of brain surgery?	Yes or No	Have a history of back surgery?	Yes or No
Have a prosthetic/implant of any kind?	Yes or No	Have a history of heart surgery?	Yes or No
Have an ear implant?	Yes or No	Any chance of pregnancy or IUD in place?	Yes or No
Have an aneurysm clip?	Yes or No	Have any metal anywhere in your body?	Yes or No
Have any metal fragments in your eyes?	Yes or No	are you breast-feeding?	Yes or No

Please sign below to acknowledge you have read and understand this screening form.

____ ______________________________

PATIENT'S SIGNATURE OR PARENT IF A MINOR **WITNESS**

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PATIENT INTAKE FORM

ASSIGNMENT OF PROCEEDS, CONTRACTUAL LIEN AND AUTHORIZATION

TO: DFW MRI, L.P. AND RADIOLOGIST

I hereby direct any and all insurance carriers, attorneys, agencies, government departments, companies, individuals, and/or other legal entities (‘payers”), which may elect or be obligated to pay benefits to me for any medical conditions, accidents, injuries, or illness, past or future (“condition”), to pay directly to, and exclusively in the name of DFW MRI, L.P. such sums as may be owing to DFW MRI, L.P. for charges incurred by me, including but not limited to charges for treatment, narrative reports, depositions, testimony and any other charges incurred by me at the Office (“charges”). I further grant a contractual lien to DFW MRI, L.P. with respect to my charges, applicable to all payers; however, I understand that nothing in this Agreement shall be constructed as an election by DFW MRI, L.P. to claim protection under any statutory lien law. For the purpose of this Agreement, “benefits” shall include, but shall not be limited to, proceeds from any settlement, judgment, or verdict, as well as any proceeds relating to commercial health or group insurance, disability benefits, worker’s compensation benefits, medical payments benefits, personal injury protection, lost wages benefits, lost services benefits, no-fault coverage, uninsured and underinsured motorist coverage, third-party liability distributions, malpractice proceeds, attorney retainer agreements, and any other benefits or proceeds payable to me for the purpose stated herein, regardless of whether such proceeds are related to my charges or not.

I further agree that, in a payer refuses to pay DFW MRI, L.P. I hereby assign to the Office, insofar as permitted by law, the following: all of my rights, remedies, and benefits to DFW MRI, L.P. as well as any and all causes of action that I might have against such payer to the extent of my charges, the right to prosecute such causes of action either in my name or in the office name, and the right to settle or otherwise resolve such causes of action as the Office sees fit. In the event that I retain one or more attorneys to represent me in this matter, I hereby direct each attorney to issue a letter of protection to this office regarding my charges. Upon issuance, I hereby agree that such letter(s) of protection cannot be revoked or modified without the expressed written consent of this Office regarding and Funds received by the attorney relating to my accident, to promptly pay the Office out of such funds, and to the Office upon its request I hereby direct all payers to release to DFW MRI, L.P. any information regarding any coverage or benefits which I may have including, but not limited to, the amount of coverage, the amount paid thus far, and the amount of any outstanding claims.

I authorize this office to release any information regarding my treatment which pertains to my case(s) to all payers as defined above to facilitate collection under this Agreement. I hereby direct this Office to file a copy of this Agreement, together with any applicable charges, with any or all payers, regardless of whether a claim has been established with said payers, I hereby authorize DFW MRI, L.P. to endorse / sign my name on any and all checks listing me as a payee which are presented to this Office for payment of an account relating to me, my spouse, or any of my dependents. I further authorize DFW MRI, L.P. to apply any credit balance on charges incurred by me to any other outstanding charges still owed by me, my spouse, or dependents, regardless of whether these other charges are related to my condition.

I understand that I remain personally responsible for the total amount due DFW MRI, L.P. for their services. This Agreement does not constitute any consideration for this Office to await payment and it may demand payment from me immediately upon rendering services at its option. If this Office must take action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse DFW MRI L.P. for all cost of such collection efforts, including but not limited to, all court costs and all attorney fees.

This Agreement shall not be modified or revoked without the mutual written consent of DFW MRI, L.P. and myself. I hereby revoke any previously signed authorizations, whether executed at this office or any other office to the extent that the term, of those authorizations conflict with the terms of this Agreement.

I agree that each and every provision of this Agreement is reasonable and necessary for the protection of the rights and interest of DFW MRI, L.P. and me. However, should any provision of this Agreement be found to be invalid, illegal or unenforceable, or for any reason cease to be binding on any party hereto, all other portions and provisions of this Agreement shall, nevertheless, remain in full force and effect?

Patient Name (please print):____

Patient Signature: ____ Date _____-_____-_____

Name of custodial parent or legal Guardian (please print):_____________________________________

Parent/Guardian’s Signature: ____

Witness: ____

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PATIENT INTAKE FORM

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: ____ Date of Birth: _________________

Address: ____

City: ______________________________ State: ______________ Zip: __________________

Date Records Requested: ______/______/_______ Date Records Released: ______/______/______

I, THE UNDERSIGNED, AUTHORIZE DFW MRI TO RELEASE MY MEDICAL RECORDS AND MY MEDICAL BILL TO MY DOCTOR AND / OR MY ATTORNEY:

RELEASED TO DOCTOR ☐

____

____

____

____

PHONE: ______________________________

RELEASED TO ATTORNEY ☐

____

____

____

____

PHONE: ____________________________

My request for this particular release of medical records includes the following specific records (please include inclusive dates and/or specific type of records): ALL☐
MRI REPORTS AND BILLING DATED ______/______/_______

____

Instructions: ____
The facility and its doctors are hereby released and discharged from any liability, and the undersigned will hold the facility and its doctors harmless for complying with this authorization.

Patient Signature: _________________________________Relationship: _____________ Date: _____/_____/_____

Notice to person or agency receiving this information: this information has been disclosed to you from records whose confidentially is protected. Statutes and regulations prohibit you from further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other general information is not sufficient for this purpose.

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PATIENT INTAKE FORM

VERIFICATION OF NON-PREGNANCY

TEN DAY GUIDELINES FOR FEMALE PATIENTS

It is the ethical and legal responsibility of **DFW OPEN MRI LP**. To prevent the accidental irradiation of an unrecognized pregnancy. In accordance with national standards, we require the following information of female patients of child bearing age. If the information below indicates even a remote possibility of pregnancy, you may be required to undergo a pregnancy test prior to any examination involving radiation to the pelvic area.

1. Have you had a hysterectomy or already gone through menopause? ☐YES ☐NO
   Date of hysterectomy: ____________________________________.
   If "yes" do not complete the rest of this form.

2. Are you now pregnant or do you think you may be pregnant? ☐YES ☐NO
   If "yes" please notify our staff immediately!

3. Please give the first day of your last period. __________________
   Does this fall within the last ten (10) days? Date

4. Are you currently practicing any of the following birth control methods?
   Please check the appropriate box.

Tubal Ligation	☐	Birth Control Pills	☐
Foam	☐	Partner Vasectomy	☐
IUD	☐	Diaphragm	☐
Condom	☐	Norplant	☐
Other	☐	None of the above	☐

5. Have you had any sexual activity since your last menstrual period that may place you at risk of pregnancy?
   YES ☐ ☐NO

I have been fully informed as to the risk of radiation of the unborn fetus. I understand that this risk includes miscarriage, congenital deformities, and on eightfold increased incidence of leukemia during the subsequent childhood. I deny all possibilities of being pregnant at this time and give my consent to having diagnostic radiological procedures performed on me.

Patient Signature: ____ Age: _______________________________
Patient Name printed: ____
Signature of other legally responsible person: ____
Relationship to the Patient: ____
Legal responsible person printed: ____
Technologist signature: _______________________________________ Date: _________________________________

****

This patient is not within our guidelines for adequate birth control. However, her physician ________________________,
Insists this patient have x-rays exam performed today.

Radiologist Signature: ____

PATIENT INTAKE FORM

Complaint Resolution Process Policy

DFW OPEN MRI shall inform all patients at the time of services rendered of a policy for receiving complaints and concerns about the care of services. This is done so that we know our patients understand that we have our policy in place and they can be insured their concerns will be handled in a timely manner.

Patient Name: ________________________________

Concern of
Complaint____
____
____
____
____

Office Administrator Signature:
____

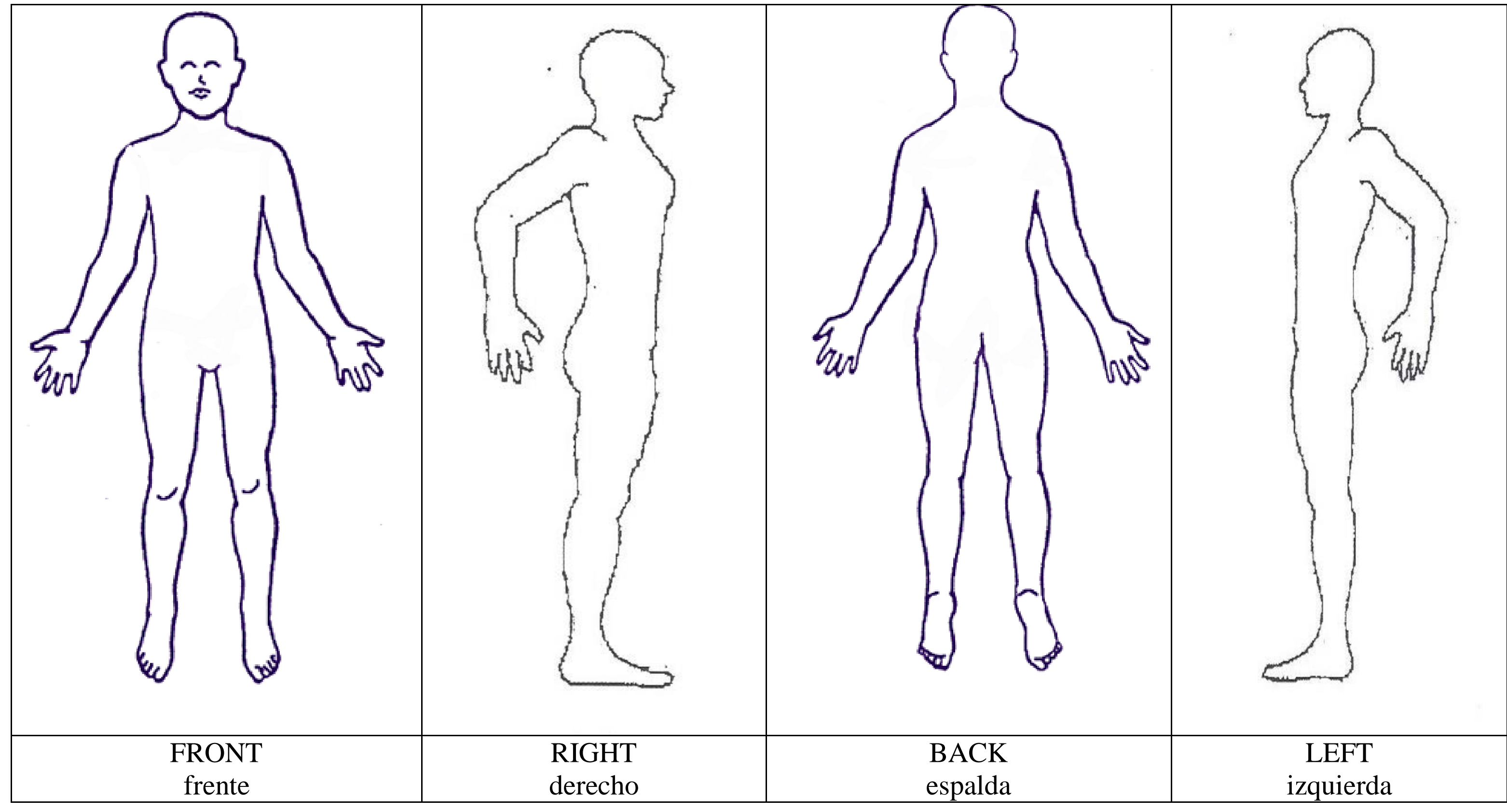
PATIENT INTAKE FORM

PATIENT PAIN DRAWING

PATIENT NAME: ______________________________________ DATE _______________

Using the symbols given below, mark the areas on your body
Where you feel the described sensations. Include all affected
Areas, Just to complete to picture, please draw in your face.

ACHING	NUMBING	PINS & NEEDLES	BURNING	STABBING	OTHER
+++++++	=======	::::::::::	XXXXXXX	///////	ooooooo
Dolor	Entumecimiento	Hormigueo	Ardor	Punalada	Otro



PATIENT INTAKE FORM

ATTENTON ALL PATIENTS!

PLEASE MAKE SURE YOU LOCK UP ALL YOUR BELONGINGS IN THE LOCKER YOU ARE ASSIGNED TO AT THE TIME OF YOUR PROCEDURE.

DFW IS NOT RESPONSIBLE FOR ANY PERSONAL BELONGINGS!
TAKE YOUR KEY WITH YOU, WHILE HAVING YOUR PROCEDURE.
WHEN RETURNING AND REMOVING YOUR PERSONAL BELONGINGS, FROM THE LOCKER, LEAVE THE KEY IN THE LOCK.

ATENION A TODOS LOS PACIENTES!

Por favor, asegúrese de bloqueo hacia arriba todas sus pertenencias en el armario que se le asigne en el momento de su procedimiento.

DFW NO ES REPONSABLE DE LOS ARTICULOS!

DFW NO ES RESPONSABLE DE LOS EFECTOS PERSONALES!
TOMAR SU CLAVE CON USTED, mientras que haciendo su procedimiento.
Al regresar Y EXTRACCIÓN sus pertenencias personales, DESDE EL LOCAL, dejar la llave en la cerradura.

NAME: ____________________
DATE: _______________________

SIGN YOUR NAME

KS/BS
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PATIENT INTAKE FORM

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACE PRACTICES

PATIENTS NAME: ______________________________

I HEREBY ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF DFW OPEN MRI LP;S NOTICE OF PRIVACY PRACTICES. I UNDERSTAND THAT I HAVE THE RIGHT TO REFUSE TO SIGN THIS ACKNOWLEDGEMENT IF I SO CHOOSE.

____ ________________________________

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE DATE

PRINT NAME OF PATIENT'S REPRESENTATIVE (IF APPLICABLE)
NAME: ____

CHECK ONE

		PARENT OF GUARDIAN OF UNEMENCIPATED MINOR
		COURT APPOINTED GUARDIAN
		EXECUTON OR ADMINISTRATOR OF DECEDEN'S ESTATE
		COMMUNICATION BARRIERS PROHIBITED OBTAINING ACKNOWLEDGEMENT (EXPLAIN)

****
FOR OFFICE USE ONLY

WE ATTEMPTED TO OBTAIN WRITTEN ACKNOWLEDGEMENT OF RECEIPT OR OUR NOTICE OF PRIVACY PRACTICES ON THE FOLLOWING DATE _______________
BUT ACKNOWLEDGMENT COULD NOT BE OBTAINED BECOUSE.

CHECK ONE

	PATIENT /REPRESENTATIVE REFUSED TO SIGN
	EMERGENCY SITUAR=TION PREVENTED US FROM OBTAINING ACKNOWLEDGEMENT AT THIS TIME
	COMMUNICATION BARRIERS PROHIBITED OBTAINING ACKNOWLEDGEMENT (EXPLAIN)