Patients Name: _____

Street Address: _____

City/State/Zip Code: _____

Home Phone #:_____-_____-_____

Cellular Phone #:_____-____-_____

Social Security#:_____-_____-_____

Gender: MALE FEMALE

Marital Status: SINGLE/ MARRIED/ DIVORCED/ WIDOWED

Date of Birth: _____-_____-_____

Referring Physician: _____

I herby authorize my insurance to be paid directly to the above facility, realizing that I am responsible to pay non-covered services and I herby authorize the release of pertinent medical information to the insurance carriers.

Signature: _____

Date: _____/_____/_____

MUNSTER OPEN MRI & IMAGING

1) Any chance of being pregnant? YES NO N/A LMP: _____

2) List any types of surgeries within the area of interest for todays' exam: _____
_____

3) Please explain your symptoms in detail: _____

_____

4) Are you over the age 60? YES NO
5) Are you Diabetic? YES NO
6) Any history of any of the following? (Please Circle)

Kidney Disease	Single Kidney	Sickle Cell
Kidney Failure	Multiple Myeloma	

A patient who answers yes to any of the questions above (1-3) must have a recent lab test with a BUN and a creatinine or a GFR within the past 60 days. The patient must obtain a copy of the lab results from their physician and bring it with them to their appointment. If the labs were abnormal (high) the labs must be redrawn and resulted before the CT can be done with contrast.

7) Are you allergic to IODINE? YES NO
8) If yes, what kind of reaction did you have?

_____

_____

A patient who answers yes to number 4 must be brought to the attention of the ordering physician. The physician may decide to do the test without contrast (labs will not be necessary) or the physician may choose to pre-medicate their patient. The pre-medication is a 13 hour prep in which the physician must order through the patient's pharmacy. The pre-medication prep can be faxed to the physician if needed.

9) If you are allergic to iodine have you been pre-medicated for today's exam? YES NO
10) What other medications are you allergic to (if any)?

_____

_____

11) Did you bring a copy of your most recent lab work? YES NO
12) Please list the names of your current prescribed medications:

_____

Comments: _____

_____

Patient Signature _____ **Date** _____

MUNSTER OPEN MRI & IMAGING

Notice of Privacy Practice Acknowledgement

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in my care.
Obtain payment from third party payers
Conduct normal healthcare operations such as quality assessments and physician certifications

I understand the Notice of Privacy Practices. I understand that I may contact Munster Open MRI and Imaging at any time to request a current copy of the Notice of Privacy Practices.

I understand that I may request in writing how my private health information is used or disclosed to carry out treatment, payment of health care operations by Munster Open MRI and Imaging.

Patient Name: _____

Signature: _____

Date: _____/_____/_____