

Appointment Date:

Last Name	First Name	MI	Date of Birth	Male	Female
Street Address				Height	Weight
City	Zip Code	Preferred Email Address			
Social Security #	Home Phone	Work Phone	Cell Phone		
Employer Name					
Insured's Name		Insured's Employer		Relationship to Patient	
Insurance		ID#			
Secondary Insurance		Secondary ID#		Secondary Insured's DOB	

Are you here as the result of a car accident?	Yes	No	
	<input type="checkbox"/>	<input type="checkbox"/>	
Are you here as the result of a work related	<input type="checkbox"/>	<input type="checkbox"/>	

- Why did you choose Zwanger-Pesiri Radiology?**
- A) Friend/Family Member Recommendation
 - B) Doctor Referral
 - C) Advertisement (Radio, Newspaper, Etc.)
 - D) Convenience (Hours, location, etc.)

Patient Name _____ Date _____

	Yes	No
Does your insurance have a deductible?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have an HSA or HRA plan?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, we need a copy of your debit card.	<input type="checkbox"/>	<input type="checkbox"/>

Authorization for Treatment: I hereby consent to treatment by the radiologist and other medical staff for all local anesthetics, radiologic tests and/or procedures as deemed necessary by myself and the Zwanger-Pesiri Radiology staff:

I am aware that additional charges may be incurred if a diagnostic mammogram is deemed necessary. I understand that according to my particular insurance plan, this may or may not be covered.

Authorization for Release of Information and Assignment of Benefits: I hereby assign to Zwanger-Pesiri Radiology, LLP those benefits otherwise payable to me by any third party as reimbursement of expenses and fees in connection with testing performed and treatment rendered. I request that payment of authorized benefits be made directly to Zwanger-Pesiri Radiology on my behalf. I fully understand that I am financially responsible for **any** and **all** amounts not otherwise paid by my insurance carrier:

I certify that the information on this form given by me for payment under Title XVIII (Medicare) is correct and complete. I authorize holder of medical or related information about me to be released to the Health Care Financial Administration (HCFA) and/or other health care coverage entity, any information needed of this or any related healthcare claim in writing or verbally. I further understand and agree to pay for services or amounts due when denied as not covered by Medicare or any other health insurance plans

I hereby authorize release of my films, images, reports and medical records as needed for subsequent medical care. In event of positive findings I authorize release of my results to my referring and treating physicians for their records.

I acknowledge that I have been provided with a copy of the Zwanger-Pesiri Radiology's Notice of Privacy Practices.

In addition, I give the right for Zwanger-Pesiri Radiology, LLP to contact the following person(s) to discuss medical treatment and/or billing information:

Persons(s)	Relationship	Phone#
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This authorization will remain in effect unless changed by me, while I am a patient of Zwanger-Pesiri Radiology, LLP.

Pregnancy Denial Statement

Women age 12-55 (except ultrasound)

I hereby attest that there is **NO** possibility that I am pregnant.

Patient signature

Patient Name _____ Date _____

MRI Questionnaire

IF you answer **yes** to **any** of these next 10 questions, notify the staff, nurse and technologists

- Yes/No Do you have a Pacemaker or Defibrillator?
- Yes/No Do you have an implanted infusion pump?
- Yes/No Do you have an implanted hearing aid?
- Yes/No Do you have a cerebral aneurysm clip?
- Yes/No Did you bring documentation to confirm MRI compatibility of any implanted mechanical device, pump simulator etc.?
- Yes/No Have you ever had metallic foreign body in your eye?
- Yes/No Have you ever been a machinist or metal worker?
- Yes/No Do you have any drug patches on any part of your body?
- Yes/No Do you have any prosthetics?
- Yes/No Do you have breast tissue expanders?

Remove hearing aids before entering the MRI room.

If you are you currently breast feeding, you should not have IV contrast (gadolinium)

All Patients

Reason for this MRI study, list symptoms _____

- Yes/No Have you had an MRI before? If yes, where, when, and what body part _____
- Yes/No Are you allergic to Gadolinium (MRI contrast)? If yes, list and describe symptoms: _____
- Yes/No Do you have diabetes?
- Yes/No Do you have any history of kidney failure? If yes, when? _____
- Yes/No Recent abnormal blood tests? List type and results: _____
- Yes/No Do you have any abnormal lumps or masses? Where? _____
- Yes/No Do you have any medical conditions? If yes, list and describe treatment: _____
- Yes/No Have you had any surgery? If yes, list type and date: _____
- Yes/No Do you take a medication called Hydroxyurea?

Cancer Patients Only

- Yes/No Do you currently or have you previously had cancer? If yes, what type and treatment _____
- Yes/No Have you had radiation therapy? If yes, list body part: _____
- Yes/No Have you had chemotherapy? If yes, list date of last treatment: _____

Pain and Injury Patients Only

- Yes/No Have you had any recent injury? When and what type? _____
- Yes/No Do you have any tenderness to touch? Where? _____
- Yes/No Do you have any pain? Where? _____

Consent for IV Contrast Material: If your physician has requested or if the radiologist feels your condition/findings warrant, you may receive IV contrast material. The contrast is injected through a small needle placed in a vein in your arm or hand, much the same manner as when blood is drawn for laboratory studies. Occasionally a patient may have a mild reaction to the contrast agent and will develop sneezing or hives. Other or more severe reactions may occur but are uncommon. I understand this and give consent for the use of contrast during my MR scan. All my questions regarding contrast and potential reactions have been answered to my satisfaction.

Signature of patient /parent/guardian for contrast consent

Date

Patient Name _____

Date _____

I understand that payment is due at the time of service and that I am financially responsible for ANY and ALL amounts not otherwise paid by my insurance carrier.

I UNDERSTAND THAT MY ACCOUNT WILL BE SUBJECT TO AN ADDITIONAL \$15.00 PROCESSING FEE EACH MONTH IF PAYMENT IS NOT RECEIVED BY THE DUE DATE INDICATED ON MY BILLING STATEMENT.

I further attest that the information I have provided on these **forms** are true to the best of my knowledge

Patient or Legal Guardian Signature *Date*

Please sign here

