BLUE STAR IMAGING | BOERNE

MRI SCREENING FORM

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth: _____ ☐ Male ☐ Female Weight: _____ Height: _____

What symptoms are you experiencing? _____

Referring Physician: _____

ARE YOU DIABETIC OR HAVE RENAL DISEASE? ☐ YES ☐ NO **CLAUSTROPHOBIC?** ☐ YES ☐ NO

PLEASE CHECK BELOW ALL OF THE MEDICAL CONDITIONS THAT APPY TO YOU:

☐ **Yes** ☐ **No** Cardiac Pacemaker
☐ **Yes** ☐ **No** Implanted Insulin Pump
☐ **Yes** ☐ **No** Implanted Drug Infusion Device
☐ **Yes** ☐ **No** Neurostimulator
☐ **Yes** ☐ **No** Biostimulator
☐ **Yes** ☐ **No** Aneurysm Clip
☐ **Yes** ☐ **No** Heart Valve Prosthesis
☐ **Yes** ☐ **No** Cardiac or Vascular Stents
☐ **Yes** ☐ **No** Any Type of Surgical Clips or Staples
☐ **Yes** ☐ **No** Hearing Aid (Internal or External)
☐ **Yes** ☐ **No** Body Piercing, if yes, where: _____
☐ **Yes** ☐ **No** History of Cancer, if yes, where: _____
☐ **Yes** ☐ **No** Stroke

☐ **Yes** ☐ **No** Ear Implants or Other Surgery
☐ **Yes** ☐ **No** Penile Prosthesis
☐ **Yes** ☐ **No** Intraventricular Shunt
☐ **Yes** ☐ **No** Orbital or Eye Implant
☐ **Yes** ☐ **No** Wire Mesh
☐ **Yes** ☐ **No** Orthopedic Implants/Devices(Rods, Pins)
☐ **Yes** ☐ **No** Seizures
☐ **Yes** ☐ **No** Dentures, Dental Braces, Partial Plates
☐ **Yes** ☐ **No** Heart Disease
☐ **Yes** ☐ **No** Possibility of Metal Fragments (From Welding or Other Machine Work)
☐ **Yes** ☐ **No** Shrapnel or Bullets Within Your Body
☐ **Yes** ☐ **No** Other _____

DO YOU HAVE ANY DRUG ALLERGIES? IF YES, PLEASE LIST MEDICATIONS BELOW: ☐ YES ☐ NO

_____

LIST PREVIOUS SURGERIES:

_____

FEMALE PATIENTS ONLY

☐ **Yes** ☐ **No** Is there a chance that you are pregnant?
☐ **Yes** ☐ **No** Are you currently pregnant?
☐ **Yes** ☐ **No** Have you had a hysterectomy or tubal ligation?
☐ **Yes** ☐ **No** Are you currently nursing?

FORM OF BIRTH CONTROL

☐ Abstinence
☐ Birth Control Pills/Patch
☐ Diaphragm
☐ Vasectomy
☐ Condom
☐ IUD
☐ Menopause
☐ None

I attest that the information I have provided for myself or family member is correct to the best of my knowledge and I hereby give consent for my procedure:

Patient Signature: _____ Date: _____

Technologist Signature: _____ Date: _____

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112 Herff Road| Suite 150 | Boerne , Texas 78006
Phone: 210.961.4282 | Fax: 210.961.4283

CONSENT FOR ARTHROGRAMS/STEROID INJECTIONS

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth: _____ ☐ Male ☐ Female

What symptoms are you experiencing? _____

Have you had surgery to the area we are injecting? _____

Are you allergic to any medication? _____

If yes, please list: _____

Do you have a history of allergic reactions to local anesthetic and/or a contrast medium (dye) used for an MRI, CT or X-Ray examination? _____

FEMALE PATIENTS ONLY

☐ **Yes** ☐ **No** Is there a chance that you are pregnant?
☐ **Yes** ☐ **No** Are you currently pregnant?
☐ **Yes** ☐ **No** Have you had a hysterectomy or tubal ligation?
☐ **Yes** ☐ **No** Are you currently nursing?

FORM OF BIRTH CONTROL

☐ Abstinence
☐ Birth Control Pills/Patch
☐ Diaphragm
☐ Vasectomy
☐ Condom
☐ IUD
☐ Menopause
☐ None

What is the date of your last menstrual cycle? _____ To _____

I have informed the technologist that I am NOT pregnant at this time.

Signature: _____ Date: _____

Your doctor has requested that you have an injection of contrast material (iodine based and/or MR contrast) or steroid. For an arthrogram, your physician feels that your scan may produce the best possible diagnosis using this method.

Local anesthesia will be administered under the skin. A small needle will be placed into your joint using sterile technique. Contrast and saline will be injected into your joint under image guidance. You will feel a pressure-like discomfort in your joint for 24-48 hours.

The following complications are possible:

Anytime an injection is given there is the potential for pain, bleeding, bruising or swelling at the injection site. Untreated complications could lead to loss of use of the joint. You can expect pain or soreness lasting up to 24 hours after the injection. Additional allergic reactions in response to the contrast agent may include hives, shortness of breath, or difficulty swallowing. There have been rare instances of death following the administration of the contrast agent. It is very important that you inform the technologist if you experience any of the above conditions.

I certify that this form has been fully explained to me, that I have read it or have had it read to me, and that I understand its contents. I have been given the opportunity to ask questions about the anesthesia, the procedures used, and the risks and hazards involved, and I believe that I have sufficient information to give this informed consent.

I attest that the information I have provided for myself or family member is correct to the best of my knowledge and I hereby give consent for my procedure:

Patient/Parent or legal guardian signature: _____ Date: _____

Technologist Signature: _____ Date: _____

Radiologist Signature: _____ Date: _____

OFFICE USE ONLY

Fluoroscopy Time: _____ DAP: _____ (uGy*^{m2}) Kerma: _____ (mGy)

Lidocaine:	Amount:	_____	Lot:	_____	Exp:	_____
Omnipaque:	Amount:	_____	Lot:	_____	Exp:	_____
Dotarem:	Amount:	_____	Lot:	_____	Exp:	_____
Steroid:	Amount:	_____	Lot:	_____	Exp:	_____
Saline:	Amount:	_____	Lot:	_____	Exp:	_____

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IV CONTRAST MATERIAL PATIENT CONSENT FORM

Your physician has requested that we perform a diagnostic imaging procedure(CT/MRI), which may require an injection of a contrast material into your bloodstream. The injection may provide additional diagnostic information and improve your exam. Although the vast majority of patients have no side effects from this injection, potential risks may include: pain, bleeding, bruising, swelling, mild headache, nausea, itching, or other vague symptoms for a short time after the injection. Additional allergic reactions in response to the contrast material may include: hives, shortness of breath, or difficulty swallowing.

NOTE TO PATIENTS: It is very important that you inform the technologist if you experience any of the conditions mentioned on the form.

MRI PATIENTS ONLY: People with kidney disease who are given a gadolinium-based contrast material may have a very small risk of developing a very rare disease cause Nephrogenic System Fibrosis (NSF). We screen all MRI patients with criteria recommended by the American College of Radiology. If you meet certain criteria, you may need a blood test to determine your level of kidney function. Presently, this disease has only been found in patients with kidney disease. NSF is often associated with the thickening and tightening of the skin and occasionally other organ and muscles. NSF may rarely continue to get worse and can even cause death. At Blue Star Imaging, we do not give MRI contrast to those at potential risk for developing NSF. However, despite our efforts, there is always a small risk that a patient will develop NSF.

Have you ever had contrast material injected before for a CT, MRI, X-ray or Cardiac Cath? ☐ YES ☐NO

Did you have any problems with the injection of contrast material? If yes, please explain: ☐ YES ☐NO

_____

Are you allergic to iodine or iodine containing substances? ☐ YES ☐NO

Do you have any allergies to medications? ☐ YES ☐NO

Please List: _____

Are you Diabetic? ☐ YES ☐ NO

If yes, do you take medication to control your Diabetes? (Please lis medication)

Are you breastfeeding? ☐ YES ☐ NO

DO YOU HAVE ANY OF THE FOLLOWING:

☐ Kidney Disease	☐ Lupus	☐ Dialysis	☐ High Blood Pressure
☐ Single Kidney	☐ Sickle Cell Anemia	☐ Heart Disease	☐ Chemotherapy
☐ Kidney Transplant	☐ Kidney Surgery	☐ Asthma	

List all the medications you are currently taking:

_____

I give consent to the injection of contrast material if indicated:

_____

Patient Signature _____ **Date:** _____

Technologist Signature _____ **Date:** _____

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HIPAA ACCESS TO PROTECTED HEALTH INFORMATION

Have you had a prior imaging study on the body part you are having examined today? Yes ☐ No ☐

If yes, what type of exam (circle all that apply) CT MRI ULTRASOUND X-RAY

Name of facility where exam was performed: _____

Date of Service: _____

I hereby authorize Blue Star Imaging to request protected health information on my behalf for comparison purposes.

Signature: _____ Date: _____

Print Name: _____ DOB: _____

Please Note:

At the request of your primary care physician or referring doctor, your health information and images may be visible to other physicians for continuing your patient care. The purpose of the request could be for a consultation, second opinion, and/or referral to a specialist.

It is to be understood by all parties that the permitted uses and disclosures of health information must be within the scope of the obligations and responsibilities for continued medical care, defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

____ By initialing here, you are helping streamine the process and allowing the consulting physician to view your images without further consent.

If you wish NOT to have your images available for continued care, please let the front desk know and we will note your account accordingly.

In addition to the caregiver(s) providing services and my insurance company for payment of claims, I would like for the following person(s) to have access to my protected health information (PHI).

Name(s)	**Relationship to Patient**

BILLING AND COLLECTIONS POLICY

Blue Star Imaging is committed to assisting uninsured or underinsured patients in meeting their payment obligations and to applying consistent and compliant patient billing and collection practices to all patients.

Blue Star Imaging will request payment of billed charges from uninsured/underinsured patients unless the patient qualifies for financial assistance or other programs as outlined below. Ability to pay and eligibility for other funding sources will be taken into consideration at the time services are provided. Blue Star Imaging shall not engage in any Extraordinary Collection Actions before reasonable efforts (as outlined below) have been made to determine whether or not the patient qualifies for financial assistance under the Blue Star Imaging Financial Assistance Policy.

All uninsured patients may be screened for other funding sources (i.e. insurance, third party liability, current eligibility for governmental programs); potential eligibility for other funding programs (i.e. insurance, third party liability, current eligibility for governmental programs); potential eligibility for other funding programs (i.e. Medicaid, Crime Victims, County Indigent, etc.); financial assistance through Blue Star Imaging's Financial Policy; and, ability to pay. Patients who have no other source of funding and do not qualify for financial assistance may qualify for a private pay discount or a payment plan. All patients can obtain a Financial Assistance Policy plain language summary before leaving Blue Star Imaging.

Underinsured patients can be granted the same options for private pay discounts or payment plans on a portion of their charges if they have maxed out their benefits or the services are non-covered by their insurance plan.

Once a patient qualifies for financial assistance no further action shall be taken for amounts qualifying under the Financial Assistance Policy. However, the portion of the patient charges not qualifying for financial assistance will be subject to the same billing and collection actions with other patients as outlined below.

PRESUMPTIVE AND PRIOR ELIGIBILITY PROCESS:

Blue Star Imaging will have made reasonable efforts to determine if a patient qualifies for financial assistance under the presumptive eligibility process outlined in the Blue Star Financial Assistance Policy or if the patient qualifies under prior eligibility determinations. Otherwise, the Notification Process should be followed to establish reasonable efforts.

Under these eligibility determinations, if the patient did not qualify for the most generous assistance available (financially indigent) then the patient shall be notified of ways to qualify as financially indigent and be given a reasonable amount of time before engaging in any Extraordinary Collection Actions.

NOTIFICATION PROCESS:

Once a patient account balance is established and Blue Star Imaging determines the portion of the patient's responsibility, Blue Star Imaging will send a minimum of three post-treatment billing statements over a 60-day period asking the patient to pay starting with the first billing statement. Each billing statement will notify that financial assistance is available for eligible individuals. The final billing statement sent to the patient will contain a plain language summary informing the patient about the Blue Star Imaging Financial Assistance Policy and will notify the patient that the account will be assigned to a collection agency and potentially reported to a credit agency no earlier than 30 days after the date of the final statement. Reporting to a credit agency will not occur until approximately 90 days after the first post-discharge billing statement is mailed to the patient.

In addition to the post-discharge billing statements referenced above, a phone call may be placed to patients asking for payment in full. Each time the patient is called the patient will be informed of the Financial Assistance Policy and how to apply. If payment in full is not possible and the patient does not qualify for financial assistance, then a payment plan will be offered.

Should services be related to an accident in which a third party may be liable Blue Star may file a "Lien" against any potential proceeds or coverage paid by the third party. Blue Star Imaging will not file any liens directly against any patient or their property.

Revenue cycle management has the final authority or responsibility for determining that Blue Star Imaging has made reasonable efforts to determine whether an individual is eligible for financial assistance and may therefore engage in collection actions against the patient.

_____ _____

PATIENT SIGNATURE **DATE**