WOODLAKE MRI & DIAGNOSTIC IMAGING

1065 Gessner, Suite 100
Houston , TX 77055

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

Woodlake MRI will use and disclose your personal health information to treat you. To receive payment for the care we provide, and for other health care operations. Healthcare operations generally include those activities we perform to improve the quality of care. We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies about your personal health information.
The terms of the notice may change with time and we will always post the current notice at our facility and have copies available for distribution.

I, _____, have received a copy of this facility's Notice of Privacy Practices.

_____

Signature Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but the acknowledgement could not be obtained because:

_____ Individual refused to sign
_____ Communication barriers prohibited obtaining the acknowledgement
_____ An emergency situation prevented us from obtaining acknowledgement
_____ Other (Please specify) _____

_____

_____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT
Include completed consent in the patient's Medical Record

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1065 Gessner Dr. # 100
Houston, TX 77055
Phone: 713-465-6500 * Fax: 713-465-6511

Patient Name: _____ DOB _____

MRI

Have you ever had an MRI? YES NO
What body part? _____ When? _____

Are you claustrophobic? YES NO

Have you ever had any SPINAL, HEART or BRAIN surgery? YES NO
When? _____

Any posibility you have any foreign bodies or implants in your body? YES NO
What? _____

Do you have a PACEMAKER? YES NO

Have you ever worked with metal? YES NO
Any posibility of metal fragments in your eyes? YES NO

Are you allergic to: Iodine _____ Other _____

Is there any chance of pregnancy? YES NO

Are you diabetic? YES NO
If so, list medications. _____

Any physical limitations? (wheelchair, crutches, etc.) YES NO

CT SCAN

Is there any chance of pregnancy? YES NO

Are you allergic to: Iodine _____ Other _____

Are you allergic to shellfish? YES NO

Do you have kidney problems? YES NO

Are you on blood thinners? YES NO

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Patient Name: _____ Acct.: _____

If you have Medical Insurance:
Assignment of Benefits: I hereby authorize payment directly to Woodlake MRI & Diagnostic Imaging. Of any and all medical benefits applicable and otherwise payable to me. I understand I am financially responsible to Woodlake MRI & Diagnostic Imaging.

Release of Information: I hereby authorize Woodlake MRI & Diagnostic Imaging, to furnish my insurance company, Dr.'s office or companion of their representatives with any and all information that may be obtained in their medical records.

If you have Medicare:
Lifetime Medicare B Signature Authorization: I authorize Woodlake MRI & Diagnostic Imaging, to release my information needed for this or other Medicare claims to the Social Security Administration and Health Care Financing Administration on my behalf. I request all benefits be assigned to Woodlake MRI & Diagnostic Imaging, and I understand that I am responsible for my health deductibles and co-insurance.

If you have an Attorney with a Letter of Protection:
Liability/Attorney Medical Records Release: I authorize Woodlake MRI & Diagnostic Imaging, to release my medical records to my attorney.

Assignment of Benefits: I hereby authorize payment directly to Woodlake MRI & Diagnostic Imaging. I also realize I am financially responsible to Woodlake MRI & Diagnostic Imaging, regardless of the outcome of my case.

If this is a Workman's Compensation Claim:
Worker's Compensation: This authorizes Woodlake MRI & Diagnostic Imaging to furnish written reports to my doctor and communicate orally with any representative, attorney for, or investigator from the Worker's Compensation Carrier regarding my examination, diagnosis, treatment and prognosis.

If patient is under 18: I hereby give permission for _____
to be treated by Woodlake MRI & Diagnostic Imaging.

THIS MUST BE SIGNED IN ORDER TO FILE YOUR CLAIM

_____ _____
Patient/Guardian Signature Date

_____ _____
Patient unable to sign due to: Witness

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Sex: _____ Age: _____ Height: _____ Weight: _____

What type of symptoms are you having? _____

How long have you been having these symptoms? _____

What type of diagnostic tests have you undergone for this problem, with the date and location they were performed? _____

List any previous surgeries with the date and locations they were performed? _____

List any medications you are currently taking: _____

List any food and/or drug allergies: _____

I have been given an opportunity to ask questions about the exam my Doctor has ordered for me. I have also had the opportunity to ask questions about the risks involved in the diagnostic procedure to be performed. I have sufficient information to give my informed consent, and agree to proceed with the diagnostic exam(s). Also, to the best of my knowledge, I do not have any metal in my body or in my eyes (If there is a possibility, x-rays should be performed to determine whether or not there is in fact any metal inside of your body). I am refusing/agreeing to have x-rays taken, if there is a possibility of metal inside of my body. If I do refuse x-rays and have any metal inside my body or eyes, I will not hold Woodlake MRI & Diagnostic Imaging liable.

_____ _____

Patient's Signature Person Authorized to consent for minor Relationship

Female Patients Only

___Yes ___ No Are you pregnant or experiencing a late menstrual period? Date of last period. _____/_____/_____

___ Yes ___ No Are you breast feeding?

I realize that if I am pregnant and have radiation to the abdomen, there is a possibility of injury to the fetus. I therefore, give my informed consent for this procedure, and I release for myself, and as guardian of my fetus/child, this facility, and all employees or contractual employees, and the doctors, staff and other personnel or any of the foregoing entities, from any allegations, claims, or causes of action for damages resulting from my having any radiographic examination while I am pregnant.

Patient Signature: _____ Date: _____