Elite Extremity MRI of Wisconsin

Last Name: _____ First Name: _____ MI: _____

Date of Birth: ____/____/____ Sex: M F (Circle one) Weight: _____Height _____

Address: _____ City: _____ State: _____ Zip: _____

Home phone: (___) _____Cell: _____Work: _____

Email address: _____

How were you referred to our practice? _____

Ordering Physician: _____

Date of MRI Scan: _____

Examination Performed: _____

Please indicate if you have any of the following:	Circle	YES or	NO
Cardiac Pacemaker / Cardiac Valve Replacement		YES	NO
Brain Aneurysm Clip / Shunt		YES	NO
Aortic Clip / Surgical Clips		YES	NO
Implanted Neurotransmitter (electronic device)		YES	NO
Insulin Pump / Infusion device (internal / external)		YES	NO
Hearing Aids (remove)		YES	NO
Cochlear Implant / Other Internal Hearing Aid		YES	NO
Prosthetic Device		YES	NO
Joint Replacements, Metal Rod, Plates, Screws, Nails (post op 6 weeks)		YES	NO
Shrapnel, Bullet, or Other Foreign Body		YES	NO
Are you pregnant or trying to get pregnant		YES	NO
Have you had an eye injury involving metal or do you work with metal occupationally?		YES	NO
Tattoos, Body Piercing?		YES	NO
Known Allergies list: _____		YES	NO

Have you had any surgeries of the Heart, Brain, Spine or Abdomen? If yes, what was done and when?

_____

Have you had an MRI before on this same body part? If yes, at what facility and when was it performed?

_____

☐ **I have read and understand all of the above compatibility questions.**

_____

Signature of patient or Guardian Date

_____

Signature of person conducting screening Date

Elite Extremity MRI of Wisconsin, LLC

Authorization to Release Information

Many of our patients allow specified individuals such as their spouse, parent or others to call and request the results of imaging; or to contact us on their behalf to assist in explaining their statements. Under the requirements for HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have other specified individuals permitted to contact us on your behalf for the aforementioned purpose(s), you must specify to whom we may speak and you must sign this form.

I authorize Elite Extremity MRI of Wisconsin, LLC to release my results and reports; and/or to discuss matters relating to my statements with the following individuals:

1._____ Phone # (___)_____ Relationship to patient_____

2._____ Phone # (___)_____ Relationship to patient_____

3._____ Phone # (___)_____ Relationship to patient_____

Name of Patient: _____

Signature of Patient:_____ Date: _____

Authorization to Leave Message with Household Members/Answering Machine

From time to time it is necessary for representatives of Elite Extremity MRI of Wisconsin, LLC to leave a message for our patients. The purpose of these messages are to remind patients that they have an appointment, to notify the patient that technical staff would like to discuss imaging results, or to ask a patient to call Elite Extremity MRI of Wisconsin regarding an issue or concern. At no time will a representative of Elite Extremity MRI of WIsconsin discuss your imaging results without your consent. The purpose of this consent is to leave a message with a member of your household or answering machine.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Name of Patient: _____

Signature of Patient:_____ Date: _____

Elite Extremity MRI of WI - NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW PERSONAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. We respect patient confidentiality and only release personal health information about you in accordance with state and federal law. This notice describes our policies related to the use of the records of your care generated by Elite Extremity MRI of WI.
Privacy Contact: If you have any questions about this policy or your rights contact the Privacy Officer at 414-249-3250.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

In order to effectively provide you care there are times when we will need to share your personal health information with others outside of Elite Extremity MRI of WI. This includes for-
Treatment- With your permission we may use or disclose personal health information about you to provide, coordinate, or manage your care or any related services, including sharing information with others outside of Elite Extremity MRI of WI that we are consulting with or referring you to.
Payment- Information will be used to obtain payment for any treatment and services provided. This includes contacting your health insurance company for prior approval of planned treatment or billing purposes.
Healthcare Operations- We may use information about you to coordinate our business activities. This may include setting up your appointments, reviewing your care, and training staff.

INFORMATION DISCLOSED WITHOUT YOUR CONSENT

Emergencies- Sufficient information may be shared to address an immediate emergency you are facing.
Follow-up Appointments/Care- We will contact you to remind you of future appointments or regarding information about alternative treatments or other health-related benefits and services that may be of interest to you.
As Required By Law- This includes situations that involve a subpoena, court order, or a mandate to provide public health information such as communicable diseases or suspected abuse or neglect i.e. child, adult, or institutional abuse.
Coroners, Funeral Directors- We may disclose personal health information to a coroner, personal health examiner, or funeral director for the purposes of carrying out their duties.
Governmental Requirements- We may disclose information to a health oversight agency for activities authorized by law, such as audits, investigations inspections and licensure. There also might be a need to share information with the Food and Drug Administration related to adverse events or product defects. We are also required to share information with the Department of Health and Human Services to determine our compliance with federal laws related to healthcare.
Criminal Activity or Danger to Others- If a crime is committed on our premises or against our personnel, we may share information with law enforcement to aid in apprehension of the criminal. We also have the right to Involve law enforcement and to warn any potential victims when we believe an immediate danger may exist or we believe you present a danger to yourself.

PATIENT RIGHTS

You have the following rights under state and federal law:

Copy of Your Medical Records- You are entitled to inspect the personal health record we have generated about you. We may charge a reasonable fee for copying and/or mailing your record.
Release of Records- You may consent in writing to release your records to others for any purpose you choose. This includes your attorney, employer, or others who you wish to have knowledge of your care. You may revoke your consent at any time but only to the extent no action has been taken in reliance on your prior authorization.
Restriction on Record- You may ask us not to use or disclose part of your personal health information. This request must be in writing. We are not required to agree to your request if we believe it is in your best interest to permit use and disclosure of the information. The request should be given to the Program Director who will consult with the staff involved in your care to determine if the request can be granted.
Contacting You- You may request that we send information to another address or by alternative means. We will honor such a request as long as it is reasonable, and we are assured it is correct. We have a right to verify the payment information you are providing us is correct. Due to agency
policy we are not able to provide information by email.
Amending Record- If you believe that something on your record is incorrect or incomplete you may request we amend it. To do this contact the Program Director and ask for the Request to Amend Health Information form. In certain cases, we may deny your request. If we deny your request for an amendment, you have the right to file a statement you disagree with us. All filing, statements, and response will be added to your medical record.
Accounting for Disclosures- You may request a listing of any disclosures we have made related to your personal health information, except for information we used for treatment, payment, or health care operations purposes or that we shared with you or your family, or information that you gave us specific consent to release. This also excludes information we were required by law to release. To receive information regarding disclosures made for a specific time-period no longer than six years prior, please submit your request in writing to our Privacy Officer. We will notify you of the cost involved in preparing this list.
Questions and Complaints- If you have any questions or complaints, you may contact our Privacy Officer in writing at our office for further information. You may also contact the U.S. Secretary of Health and Human Services if you believe Advanced Foot and Ankle has violated your privacy rights. We will not retaliate against you for filing a complaint.
Changes in Policy- Advanced Foot and Ankle reserves the right to change its privacy policy based on the needs of the practice and lo remain in compliance with state and federal law.

_____ _____

Signature of Patient Date

_____ _____

Signature of Minor patient's parent or legal guardian Relationship to patient

PATIENT FINANCIAL POLICY

Elite Extremity MRI of Wisconsin, LLC

Thank you for choosing Elite Extremity MRI of Wisconsin, LLC. We will provide MRI services to you provided that you understand and comply with the following financial policies of our imaging facility. If you have any questions about the following, please ask to speak with one of our billing staff or technical manager.

SUBMISSION OF INSURANCE CLAIMS

YOUR HEALTH INSURANCE POLICY IS A CONTRACT BETWEEN YOU AND YOUR HEALTH INSURANCE PLAN. You are responsible for understanding and following your health plan's required procedures and policies. It is your responsibility to provide us with accurate and up-to-date insurance information, so that we can file an insurance claim on your behalf for services rendered. If we do not receive payment within 60 days from the date the claim is filed with your health plan, you are responsible for the unpaid balance and we may request immediate payment from you. All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered", you will be responsible for the complete charge. It is your responsibility to contact your health plan regarding benefits or coverage issues.

CO-PAYMENTS AND NON-COVERED SERVICES

If your health plan required a co-payment, we are required to collect it at the time of your visit. We cannot waive co-payments, deductibles or co-insurance amounts, which are the patient's responsibility. Co-payments and non-covered services are collectable at the time of your visit. If you cannot make the required payment, your appointment may be rescheduled. If you do not have health insurance coverage or request a service that is not covered by your health plan we require that payment be made in full at the time that services are rendered. For your convenience, we accept cash, personal or cashier's check, VISA, MasterCard or Discover Card payments.

PATIENT RESPONSIBILITY FOR BILLED AMOUNTS

We will send you a statement of any remaining balance on your account after health plan payments are applied. Payment is due in full within 30 days from the date that appears on your billing statement. If you cannot make payment in full, you will need to contact our billing department to arrange a payment plan. If we do not receive payment from you within 60 days from the date of the first billing notice, we will attempt to contact you for a payment. If we receive no further response within the next 30 days, your account may be turned over to our collection agency. If your account is turned over to a collections agency, you will be responsible for all collections costs and legal fees incurred.

MINORS

A parent or legal guardian must accompany a minor and consent to imaging. Parents or legal guardians must comply with the terms of this financial policy. The parent or legal guardian that accompanies the minor will be held responsible for payment of service.

MISSING, INACCURATE OR INCOMPLETE BILLING INFORMATION

You are responsible for notifying our office of any health plan or billing information changes. Failure to notify us of changes may result in your being responsible for any remaining balance on your account. Our imagine facility will not be responsible for any billing errors, lack of coverage or payment due as a result of missing, inaccurate or incomplete information that you provided us, including inaccurate information on secondary or third party payment coverage.

I have read and understand the *Patient Financial Policy* for Elite Extremity MRI of Wisconsin, LLC and accept all the terms and conditions as stated above. I have received a copy of this policy.

_____ _____

Signature of Patient Date

_____ _____

Signature of Minor patient's parent or legal guardian Relationship to patient

ELITE EXTREMITY MRI IMAGING OF WISCONSIN

DISCLAIMER

Dear Current Patient:

You will be receiving an MRI today of a musculoskeletal joint without contrast. It is imperative that you know that this MRI is only operated by multiple physicians which may or may not be treating you. You are certainly welcome to request that you be given a prescription for an alternate imaging group; however, your current physician feels that this particular MRI will give you the best read, the best diagnosis and the best value relative to the other companies that are both independent and hospital owned within the area. We are giving you this notice so that you understand that your doctor has recommended this, this is the best option for you, this is the most affordable option for you, and it may or may not be owned by the physician which has recommended this facility.

If you should have any questions, comments or concerns in regards to who owns this particular MRI or how this facility is operated, please feel free to contact Elite Extremity Imaging at the following number:

Professionally yours,

Yolanda Lugo RMA T-5

The Staff of Elite Extremity Imaging