Vision Upright MRI, LLC

828 SOUTH BASCOM AVE, SUITE 110
SAN JOSE CALIFORNIA 95128-2652
TOLL FREE: 800-704-7226 | LOCAL: 408-292-7970 | FAX: 408-292-7966
www.VisionMRI.com

Patient Demographics Sheet

☐NEW PATIENT ☐RETURNING PATIENT

PATIENT NAME_____

MARITAL STATUS: Married / Divorced / Single / Widowed / Seperated

RACE: □ Caucasian (non-Hispanic) □ Hispanic □ Asian □ African-American □ Two or more □ Decline to Answer

SSN:_____ D.O.B._____ M / F HT_____ WT_____

ADDRESS_____

CITY_____STATE_____ZIP_____

HOME_____CELL_____WORK_____

E-MAIL: _____

(IF YOU WOULD LIKE E-MAIL NOTIFICATION OF YOUR APPOINTMENTS, CHECK HERE☐)

PRIMARY INSURANCE:_____

ID:_____ GROUP#:_____ EFFECTIVE DATE:_____

POLICY HOLDER: _____ RELATIONSHIP TO PATIENT: _____

SECONDARY INSURANCE: _____

ID:_____ GROUP#:_____ EFFECTIVE DATE:_____

POLICY HOLDER:_____ RELATIONSHIP TO PATIENT: _____

PRIMARY PHYSICIAN: _____

PHONE:_____

FAX (*if available*): _____

EMERGENCY CONTACT: _____ PHONE: _____

PATIENTS SIGNATURE_____DATE_____

PARENT SIGNATURE IF MINOR_____

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Patient Screening Questionnaire

(OFFICE USE ONLY)

Patient Name:

_____

SJ

DOB: _____

The following items can interfere with MR imaging and some can actually be hazardous to your safety. Please answer Yes or No:

Yes	No		Yes	No	
__	__	Cardiac Pacemaker or (pacemaker lead wires)	__	__	Shunts
__	__	Artificial Heart Valve	__	__	Aortic Clips
__	__	Brain Aneurysm Clips	__	__	Insulin Pumps
__	__	Implanted neurostimulators or lead wires	__	__	Hearing Aids
__	__	Joint Replacement	__	__	Electrode
__	__	Metal Mesh	__	__	Piercings
__	__	Harrington Rod	__	__	Prosthesis
__	__	Dentures	__	__	Stent
__	__	Shrapnel	__	__	Wire sutures
__	__	Cochlear implant (type of hearing aid)			
__	__	Fractured bones treated with metal rods, plates, pins, screws or clips.			
__	__	Other (please specify): _____			

D.O.I._____ WORK COMP: Y / N AUTO INJURY: Y / N Y: PASSENGER/DRIVER/PEDESTRIAN

EMPLOYER: _____ PHONE: _____

ADDRESS:_____

ATTORNEY NAME: _____ PHONE: _____

TYPE OF SCAN_____ SCAN DATE_____ CONTRAST: Y/N

REFERRING DR._____PHONE_____FAX_____

FILMS _____ CD _____ CD AND FILMS _____ REPORT ONLY _____ TO PATIENT _____ DELIVER _____

NEXT APPT WITH DOCTOR_____

I, the undersigned, verify that all the answers I have provided to be true, to the best of my knowledge. I give **VISION UPRIGHT MRI, LLC** permission to perform the examination(s) requested by my physician. I authorize release of any medical information necessary to process this claim. I understand that I am responsible for all co-payments, coinsurance and services deemed "not covered" by my insurance company (if applicable). I also authorize payment of medical benefits to **VISION UPRIGHT MRI, LLC** for services rendered.

I, the undersigned, will re-direct payment to **VISION UPRIGHT MRI, LLC**, in the case where my insurance company sends payment to me. I have read the above and fully understand its content, and all my questions have been answered.

PATIENTS SIGNATURE_____DATE_____

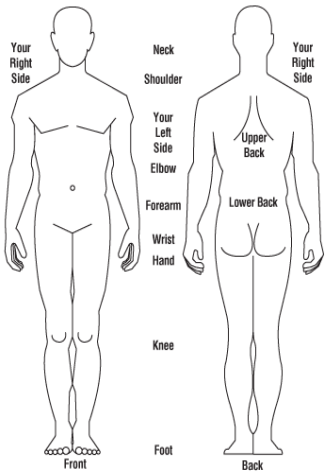
PARENT SIGNATURE IF MINOR_____

NPI: 1063662583 MRAP ID: 52368-01

PATIENT HEALTH HISTORY

1. Please shade the regions of the body associated with your symptoms and ***describe*** the symptoms and cause of injury or diagnosis, if any, from MD.

Describe:



Current Weight: _____

2. Any previous **SURGERIES** to the **BODY PART** we are scanning today? If so, what was done, how recently, and why?

3. Any previous **STUDIES** (MRI, CT, X-Ray, Ultrasound, etc.) to the **BODY PART** we are scanning today? If so, when, where, and why?

4. Are you claustrophobic? Y/N

5. Any history of cancer? If yes, explain.

Tech Notes:

ACCESSION #: SJ		
OFFICE USE ONLY		
Sequence	Start	Stop
Positioning		
Recumbent		
Neutral		
Flexion		
Extension		
Lateral Bends		
Trauma Prot.		
Injection		
Post Contrast		

Patient Authorization to Use or Disclose Protected Health Information

I, _____ understand Vision Upright MRI, LLC may use or disclose my protected health information for the purpose of treatment, payment, or health care operations unless I specifically designate differently. I specifically authorize any current employee or owner of Vision Upright MRI, LLC or any other individual listed below to disclose my protected health information as described on this form to the recipients listed below. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information. I further understand that I retain the right to revoke this authorization, if done so according to the steps set forth below.

Description of the information to be used or disclosed (*initial all that apply*).

[ ] The patient's entire medical record. [ ] Or other demographic information. Please be specific.
_____

[X] Or specific medical data/information. Please be specific.
MRI REPORT

List Name(s) (Family member/friend) or class of person(s) (i.e.: attorney) who would be authorized by this form to receive, use and disclose the patient's protected health information: If there is a code word or number you would like us to use to identify that person, please list. (Example: John Giles – chicky) Please write NONE if there is no one.

This authorization is to be used for our own use, and Vision Upright MRI, LLC will not condition treatment or payment on this authorization.

The patient has a right to revoke this authorization in writing at any time. If not revoked than authorization will remain for one year from the date of signing this form. In order for the revocation of this authorization to be effective, Vision Upright MRI, LLC must receive the revocation in writing. The revocation must include:

- The patient's name, address and patient number, if applicable.
- The effective date of this authorization, and the recipients of the protected health information according to this authorization.
- The patient's desire to revoke this authorization, and
- The date of the revocation, and the patient's signature.

Vision Upright MRI, LLC will accept written revocations of this authorization via:
Certified U.S. mail E-mail: visionuprightmri828@gmail.com Fax: 408-777-6317 or 408-292-7966

ALL revocations must be sent to Vision Upright MRI, LLC to the attention of the Privacy Officer, (Office Manager), and are not effective until received by the Privacy Officer.

I fully understand and accept the terms of this authorization. I also confirm that I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

_____ _____

Patient's Signature Date
