MRI Part A - RETAIL

Last Name: _____

First Name: _____

DOB: _____ Date: _____

Height _____ Weight _____ lbs/kgs

The MRI room contains a very strong magnet and is ALWAYS on. You MUST remove all metallic objects. Hearing aids must be removed immediately before entering the MRI room. Failure to remove such items can result in serious damage to those items and/or injury to yourself and others. Please answer the following questions carefully.

Medical/Dental procedures with sedation in the past 24 hours?	☐ Yes	☐ No
LVAD heart pump, pacemaker or pacer wires, defibrillator?	☐ Yes	☐ No
Implanted neurostimulator or TENS unit?	☐ Yes	☐ No
Medication injection device (OnPro) or pump?	☐ Yes	☐ No
Artificial heart valves/stents or aneurysm/vascular clips/grafts/shunts?	☐ Yes	☐ No
Breast tissue expander, metallic foreign body, bullet/shrapnel or any eye injury involving metal?	☐ Yes	☐ No
Small bowel endoscopy capsule or Vena Cava umbrella filter?	☐ Yes	☐ No
Recent colonoscopy or digestive system procedure involving surgical clips?	☐ Yes	☐ No
Catheter- drainage tube or temperature monitor?	☐ Yes	☐ No
Prior ear, eye or brain surgery?	☐ Yes	☐ No
List previous surgeries and dates: _____		
Hearing aids or Medication skin patches?	☐ Yes	☐ No
Pregnant? LMP: _____	☐ Yes	☐ No
Joint Replacement or orthopedic/prosthetic device?	☐ Yes	☐ No
History of Cancer? If yes, what type _____	☐ Yes	☐ No
Hair extensions/wig, braces, oral springs, removable dental work or anything held with magnets/pins?	☐ Yes	☐ No
Tattoos/Body Piercings, Glitter/permanent makeup?	☐ Yes	☐ No
DriWeave, Dri Fit or wicking clothing?	☐ Yes	☐ No
Iron deficiency being treated with Feraheme?	☐ Yes	☐ No
History of seizures or any recent falls? If yes, when? _____	☐ Yes	☐ No
Diarrhea in past 2-3 days?	☐ Yes	☐ No
Claustrophobia?	☐ Yes	☐ No
Anything in or on your body that you weren't born with?	☐ Yes	☐ No

GENERAL CONSENT/ACKNOWLEDGEMENT

I consent to the ordered exam. I understand that I have the right to refuse or stop the exam at any time and I have the right to ask questions and discuss my concerns.

I have read the screening information and answered the above safety questions accurately, and I understand I MUST REMOVE ALL METAL prior to my MRI examination.

I authorize Akumin, its subsidiaries and affiliates to bill on my behalf Medicare, or any other insurance company providing benefits to me, for services performed by Akumin and I authorize payment to be made directly to Akumin. In Medicare assigned cases, Akumin agrees to accept the Medicare "allowable charge" as the full charge.

I understand that I am responsible for the payment of any patient liability including, but not limited to, deductibles, coinsurance or non-covered charges. Self-pay/Cash pay patients are expected to pay for services at the time services are rendered unless prior payment arrangements have been made.

I have been offered a printed copy of Akumin's Notice of Privacy Practices and I acknowledge receipt of the Patient Rights and Responsibilities and the FDA GBCA Medication Guide (if contrast is to be administered).

I have read and I understand, acknowledge and agree to the content of this General Consent form and have had my questions answered. I give my consent to receive electronic communications and survey invitations if applicable.

Patient Signature: _____ Date: _____ Time: _____

(Parent or Guardian if patient is a Minor or Incapacitated) Relationship: _____