Your Awareness, Your Consent, and Your Authorization

Magnetic Resonance Imaging, or MRI, is one of the most advanced and informative diagnostic procedures. MRI is a method of obtaining images of structures inside of your body by utilizing a large magnet and radio waves, but does not involve any radiation. At American Dynamic Imaging, we have the Fonar Upright MRI machine which is a .6 magnet.

MRI AWARENESS AND CONSENT

I am aware that MRI uses a strong magnetic field & can damage Cell phone, Credit Cards, Watches, & Hearing aids.
I am aware that American Dynamic Imaging (ADI) will provide a locked area for me to place my belongings
I am aware that I am required to notify tech on duty if I am pregnant or if I have metallic devices or implants.
I am aware that my referring doctor will receive a copy of all of my medical records and it is typically their wish to go over these records with me at my next appointment. However, I am aware that I can obtain a copy of my medical records from this facility and they are available upon request for seven years.
I have described my symptoms and medical history to the best of my ability.
My signature below confirms that I am 18 years or older and able to give medical consent for myself
My signature below authorizes treatment at the ADI facility.

MY AUTHORIZATION WITH THE FACILITY INCLUDES:

My authorization to release medical information including reports, films etc. to my current doctor, any medical specialist I visit and/or my insurance company.
My authorization to release medical information to my family if directed. (See below)
My authorization for payment of medical benefits to be paid directly to the facility.
My authorization for referring doctors to release medical information to ADI.
My authorization for previous providers of care to release to ADI that information which is relative to my scan today, such as labs, previous films, studies or reports.

MY AGREEMENT WITH THE FACILITY INCLUDES:

My understanding that I may be billed for any amounts not covered by my insurance.
My understanding that I will receive a statement for services rendered and payment is due upon receipt.
My understanding that I will not receive a refund for scans completed with radiologist report for any purposes except for overpayment due to insurance.
ADI will contact my doctor regarding my referral to the facility.
ADI will contact my insurance regarding my referral to the facility.
ADI will exhaust all valid insurance avenues prior to billing me.
ADI will respect my privacy within normal industry standards.
ADI will provide me a copy of their HIPAA practices if I so request.
ADI will forward the results of my MRI to the referring doctor.

ADI may release medical information to the following designee:

By signing below, I certify that I have read and agree to the above consent and authorization.

X_____ _____

PATIENT SIGNATURE DATE

_____ _____

PATIENT REPRESENTATIVE IF APPLICABLE FACILITY REPRESENTATIVE