



The Mount Sinai Hospital

One Gustave L. Levy Place
New York, New York 10029

Name: _____

DOB: ___/___/___

Gender: M / F

MRN: _____

Location: _____

Physician: _____

DEPARTMENT OF RADIOLOGY MAGNETIC RESONANCE IMAGING (MRI) PATIENT SCREENING QUESTIONNAIRE

INSTRUCTIONS: Please answer each question below. Your responses will allow us to determine your eligibility for an MRI scan. Each box should be marked **individually**—please do not simply draw a line down a column.

Yes No

- 1. Do you have a **pacemaker, AICD, internal pacing wires, EKG leads or Holter monitor**?
- 2. Have you had **brain surgery** or do you have **metallic clips (aneurysm clips)** in your head?
- 3. Do you have an implanted **stimulator** (including **bone growth stimulator, spinal stimulator or cochlear or other ear implant**) or **medication infusion pump**?
- 4. Have you ever had eye surgery or implants?
- 5. Have you ever worked around a **metal lathe**, had **metal shavings or fragments** in your eye(s), or had a **shrapnel** (war or gunshot) injury anywhere in your body?
- 6. Have any devices (e.g., **stent, filter, coil or vascular port/catheter**) been placed in your blood vessels?
- 5a. If you do have a stent, is it **drug-eluting**?
- 7. Do you have an implanted **tissue expander**?
- 8. Do you have a **replaced heart valve**, other **prosthesis** or any other **surgical implant**?
- 9. Do you have any **tattoos, permanent make-up, or piercings**?
- 10. Do you wear **hearing aid(s)**, either in the ear canal or on the surface? (*Remove before entering room*)
- 11. Do you wear a transdermal **medication patch** (e.g., Nitroglycerin, Nicotine, etc.)?
- 12. Do you have **kidney/renal disease, liver disease, or diabetes**?
- 13. Do you have any **allergies**? If so, specify: _____
- 14. Are you **claustrophobic** (afraid of enclosed or tight spaces)?
- 15. Are you wearing a **RFID or Radiofrequency ID device** (commonly a wristband on an inpatient)?
- 16. If female, are you (or could you be) **pregnant** or are you **breastfeeding**?
- 17. List **any other** type of metal in or on your body: _____
- 18. Patient **age**: _____ years
- 19. Approximate patient **weight**: _____ (pounds) and patient **height**: _____ (feet-inches)



WARNING: Do not enter the MR system room or MR environment if you have any question or concern regarding an implant, device or object. Consult the MRI Technologist or Radiologist BEFORE entering a MR system room. **The MR magnet is ALWAYS on.**

20. Please print name, sign, date and time

PRINTED NAME _____

X _____
SIGNATURE

Patient Physician
 Relative Other:

DATE: ___/___/___ TIME: ___:___

FOR COMPLETION BY MRI PERSONNEL REVIEWING FORM

RFID removed Yes No N/A

DATE: ___/___/___

TIME: ___:___

MRI TECHNOLOGIST TECH SIGNATURE _____

DATE: ___/___/___

MRI NURSE NURSE SIGNATURE _____

TIME: ___:___



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**DEPARTMENT OF RADIOLOGY
MAGNETIC RESONANCE IMAGING (MRI)
PATIENT INFORMATION**

INFORMATION ABOUT SCANNING

The MR scan you are to have will be performed on a state-of-the-art machine that uses a very strong magnetic field. There are no known harmful effects. The magnetization may, however, interfere with the working of a cardiac pacemaker and can move pieces of magnetized metal. Because of this, we ask you to answer all of the questions on this brief questionnaire on the reverse side of this sheet.

You will be placed in a long chamber in the middle of the machine. Although the fit may seem close, the space you are in is open at both ends and the technicians are constantly in communication with you via a microphone system. If you are uncomfortable, they can hear you if you simply speak in a normal voice.

You will hear a loud clicking or knocking noise sound. That is a normal function of the machine. There are no moving parts and nothing will touch or harm you. You will be given earplugs.

As with regular pictures, if you move, you will ruin the images. Because of this, it is very important that you remain still and breathe normally while the scans are being taken.

It is our hope to make this necessary examination as comfortable for you as possible. We will be glad to answer any questions that you may have regarding the study.

PLEASE ANSWER QUESTIONS ON FRONT OF THIS SHEET, AND SIGN AT THE BOTTOM.

Thank You!

**Icahn School of Medicine at Mount Sinai
Mount Sinai Doctors Faculty Practice
Financial Agreement**

Welcome to Mount Sinai Doctors Faculty Practice (MSDFP), a division of the Icahn School of Medicine at Mount Sinai. We are committed to providing you with the best possible care and are pleased to explain our professional fees to you at any time. Your clear understanding of our Financial Agreement is important to our professional relationship. Please ask if you have any questions about our fees, our financial policy, or your financial responsibility.

PATIENTS MUST FILL OUT PATIENT INFORMATION FORMS PRIOR TO SEEING THE DOCTOR. WE WILL ALSO PHOTOCOPY YOUR INSURANCE CARD(S) FOR YOUR FILE.

- **REFERRALS** – If your plan requires a referral from your primary care physician, it is YOUR responsibility to obtain it *prior to* your appointment and have it with you at the time of your visit. If you do not have your referral, and cannot obtain one at the time of your visit, you will be personally responsible for that day's services.
- **CO-PAYMENTS** – By law we MUST collect your carrier's designated co-pay. This payment is expected at the time of service. Please be prepared to pay the co-pay at each visit.
- **OUT OF NETWORK PLANS** – If your provider does not participate with your plan, payments for any co-insurance, deductible and non-covered amount is expected at the time of service *unless* prior arrangements have been made with our financial staff. We will send a courtesy bill to your insurance carrier on your behalf.

Private Insurance Authorization for Assignment of Benefits/Information Release: I, the undersigned, authorize payment of medical benefits to MSDFP for any services furnished. I understand that I am financially responsible for any amount not covered by my health insurance contract. I also authorize any holder of medical information about me to be released to my insurance company (or its agent) concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims for benefits.

- **SELF-PAY PATIENTS** – Payment is expected at the time of service unless other financial arrangements have been made prior to your visit.
- **MEDICARE** – We will submit claims to Medicare. You will be responsible for the deductible and the 20% co-insurance, which can be billed to a secondary insurance if you have one.

Medicare Lifetime Signature on File: I request that payment of authorized Medicare benefits be made on my behalf to MSDFP for any services furnished to me. I authorize any holder of medical information about me to release it to the CMS (and its agents) to determine the benefits payable for related services. This information will be used for the purpose of evaluating and administering claims for benefits.

- **DIVORCED/SEPARATED PARENTS OF MINOR PATIENTS** – The guarantor is responsible for payment for services rendered. MSDFP cannot be involved with separation or divorce disputes.

You are responsible for the timely payment of your account. Our financial staff will work closely with you and your carrier to avoid sending any account to an outside agency to collect payment. We reserve the right to send delinquent accounts to an outside collection agency.

We accept CREDIT CARDS (MASTERCARD, VISA, or AMERICAN EXPRESS), CASH, or CHECKS. **Our preferred method of payment is by credit or debit card.**

THANK YOU for taking the time to review our policies. Please feel free to ask any questions or share any special concerns you may have with a member of our staff.

Patient Name:	Patient Signature:	Date of Birth:
Patient Address:	City, State:	Zip:
Today's Date:		
Guarantor Name: (if not the patient)	Guarantor relationship to patient:	Guarantor Signature:



**Mount
Sinai
Doctors**

AUTHORIZATIONS AND ASSIGNMENTS



1. FINANCIAL AGREEMENT/GUARANTEE OF PAYMENT (All Patients) Yes No (Please initial) _____

In consideration of services, assignment of benefits and care rendered; I agree that I am responsible for any and all charges billed by Drs. _____ (the "Physicians") with respect to such services and care unless the contract between the Physicians and my insurance company provides otherwise. In the event that the requested services are not specifically authorized by my insurance company, I agree to pay for all services as agreed upon, unless otherwise provided by law.

I authorize payment of medical benefits to which I am entitled directly to the Physicians, to cover the cost of the care and treatment rendered to myself or my dependents in the office.

Upon receipt of a medical bill, I agree to immediately pay all amounts not covered by insurance. If any insurance I have rejects my claim or pays part of the claim, I shall be responsible for payment of any balance as determined by Mount Sinai immediately upon learning of such coverage, unless otherwise provided by law.

2. RELEASE OF INFORMATION Yes No (Please initial) _____

In the event my insurer denies payment to the Physicians for services rendered to me, I hereby give my consent to have an authorized representative of the Physician to contact my insurer and to provide to my insurer all information and documentation regarding the services rendered to me by the Physicians which may be required in order for my insurer to reevaluate its decision to deny payment for such services.

I authorize this practice, my treating physician, and their respective designees to use and disclose my health information for all necessary treatment, payment and health care operations purposes. I acknowledge that my health information may include information relating to mental illness and/or AIDS/ARC/HIV and that any such information may be disclosed (including examination and copying in either hard copy or digital format) to insurers, various credit agencies and guarantors solely if needed for payment of the professional charges (no clinical information will be disclosed to any credit agency).

3. MEDICARE-RELEASE OF INFORMATION & ASSIGNMENT OF BENEFITS (Medicare only - Part B providers) Yes No (Please initial) _____

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and Centers for Medicare and Medicaid Services or its intermediaries or carriers any information (including information relating to mental illness and/or AIDS/ARC/HIV) needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign benefits payable to physician (s) and/or the (s) or organizations providing the service (s)

4. INSURANCE NETWORK/PROVIDER NOTICE PURSUANT TO NYS "OUT-OF-NETWORK" LAW

I understand that the Physicians may be participating providers in certain health plan networks, and that a list of the plans that the Physicians participate in can be found on their website or can be provided to me upon request.

I understand that the Physicians may not participate in the same health plans and networks as the hospitals and facilities in the Mount Sinai Health System even though the Physicians may be employed by or affiliated with hospitals or facilities in the Mount Sinai Health System. I understand that I can determine the health plans participated in by physicians who are employed or contracted by Mount Sinai to provide hospital services by visiting <http://www.mountsinai.org/patient-care/find-a-doctor> ; I also understand that I can also determine the health plans accepted by hospitals and facilities in the Mount Sinai Health System by visiting the facility's web portal.

I understand that the Physicians charge for their services separately from the hospitals and facilities in the Mount Sinai Health System, and that any bills from hospitals or facilities in the Mount Sinai Health System for so-called "facilities" or "technical" fees will be sent separately from the Physicians bills for their "professional" services.

I understand that it is my responsibility to check with the "physician" arranging for my services regarding: (1) whether the services of any other physicians will be required for my care; and (2) whether the services of any other physicians (including but not limited to anesthesiologists, pathologists, and/or radiologists) may be reasonably anticipated to be provided in connection with my care. I further understand that I can check with the "physician" arranging for my services to obtain the contact information and/or health plan participation information for any physicians or facility whose services may be needed in connection with my care, and that I can also contact those physicians directly to obtain information regarding their health plan participation.

I HAVE READ, UNDERSTAND AND AGREE WITH THE ABOVE ITEMS.

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE DATED

RELATIONSHIP TO PATIENT WITNESS TO SIGNATURE