



Patient Registration Form

ID # \_\_\_\_\_

Form with fields for Patient, Sex, DOB, SS#, MD's Name, Phone, Home Ph, Day Ph, Ins, and Ins#.

INFORMED CONSENT MRI, WITH OR WITHOUT CONTRAST INJECTION

TO THE PATIENT: You have the right to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you make the decision whether or not to undergo the procedure after knowing the risk and hazards involved.

If you are pregnant or think that you may be pregnant please inform the center personnel at once. It is very important that you inform the technologist if you have heart valves, a pacemaker, aneurysm clips or other implanted metallic or electrical devices.

Your physician has requested that we perform a magnetic resonance imaging (MRI) examination to obtain additional information. MRI uses a magnetic field and radio waves to produce an image of the internal body parts being examined.

As part of your MRI, a contrast agent may be injected into your veins in order to produce better images of the part of your body that is being examined. The MRI procedure may be conducted without the injection of the contrast agent, but the images may not be as helpful to the radiologist and your physician.

Potential Risk- The following complications are possible: anytime and injection is given, there is potential for pain, bleeding, bruising, or swelling at the injection site. MRI exams requiring contrast may result in a mild headache, nausea, itching, or other vague symptoms for a short time after the injection.

NOTE TO PATIENTS: If you have previously had a reaction to a contrast injection, such as hives, severe itching, shortness of breath and/or any significant reaction requiring hospitalization, a history of asthma or other allergic conditions, any history of anemia, sickle cell anemia or kidney disorder, are pregnant or breast feeding, you MUST inform the technologist.

There may be other imaging alternatives, however your physician believes the MRI to be the best diagnostic test for you, considering your symptoms and conditions. The benefit of this exam is to assist your physician with a diagnosis.

I (WE) CERTIFY THIS FORM HAS BEEN FULLY EXPLAINED TO ME, THAT I (WE) HAVE READ IT OR HAVE HAD IT READ TO ME, THAT THE BLANK SPACES HAVE BEEN FILLED IN, AND THAT I (WE) UNDERSTAND ITS CONTENTS.

I (WE) HAVE BEEN GIVEN AN OPPORTUNITY TO ASK QUESTIONS ABOUT MY CONDITION, ALTERNATIVE FORMS OF ANESTHESIA AND TREATMENT, THE PROCEDURES TO BE USED, AND THE RISKS AND HAZARDS INVOLVED, AND I (WE) BELIEVE THAT I (WE) HAVE SUFFICIENT INFORMATION TO GIVE THIS INFORMED CONSENT.

Patient/Parent/Legal Guardian Signature Date Time

Witness Signature Date Time



# Rockledge MRI & PET Imaging Center

1910 Rockledge Blvd, Suite 102  
Rockledge, FL 32955  
P: (321) 636 6599 F: (321) 636-6614

## Patient Registration Form

ID # \_\_\_\_\_

Patient: _____		Sex: M / F
_____		DOB _____ Age _____
_____		SS# _____
MD's Name	Phone	Home Ph _____
_____	_____	Day Ph _____
_____	_____	Ins _____
_____	_____	Ins# _____

### ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY

*\* You have the right to refuse to sign this acknowledgement*

**\*\*YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT**

Rockledge MRI and PET Imaging Center will use and disclose your personal health information to treat you. To receive payment for the care we provide, and for other health care operations, Rockledge MRI and PET Imaging Center operations generally include those activities we perform to improve the quality of care.

The details of our Privacy Policy are disclosed in our Notice of Privacy Practices to help you understand better our policy about your health. The terms of this notice may change from time to time, but we will always post the current notice at our facility, on our website, and copies are available for distribution.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

### FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices but the acknowledgment could not be obtained because:

- Individual refused to sign
- Communication barrier prohibited obtaining the acknowledgment
- An emergency situation prevented us from obtaining acknowledgment
- Other (Please specify) \_\_\_\_\_



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_____		DOB _____ Age _____
_____		SS# _____
MD's Name	Phone	Home Ph _____
_____	_____	Day Ph _____
_____	_____	Ins _____
_____	_____	Ins# _____

I, \_\_\_\_\_ request my medical records and/or films from,

\_\_\_\_\_  
Doctor/Facility

\_\_\_\_\_  
Address

To be sent to Rockledge MRI and PET Center.

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
DOB

\_\_\_\_\_  
SS#

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date