CASTRO VALLEY
OPEN MRI

HIPAA, Health Insurance Portability and Accountability Act
Protecting Your Confidential Health Information is Important to us

Our Responsibility

I. The confidentiality of your personal health information is very important to us. Your health information includes records that we create and obtain when we provide you care. It also includes bills, insurance claims, or other payment information that we maintain related to your care. This Notice describes how we handle your health information and your rights regarding this information. Generally speaking, we are required to maintain the privacy of your health information as required by law; provide you with this Notice of our duties and privacy practices regarding the health information about you that we collect and maintain; and follow the terms of our Notice currently in effect.

Contact Information

II. After reviewing this Notice, if you need further information or want to contact us for any reason regarding the handling of your health information, please direct any communications to the privacy officer at 510-856-4800

Uses and Disclosure of Information

III. **Under federal law, we are permitted to use and disclose personal health information without authorization for treatment, payment, and health care operations.** Participants in this organized healthcare arrangement also share health information with each other, as necessary to carry out treatment, payment, or health care operations relating to the organized healthcare arrangement. We may share the minimum amount of personal health information necessary for business associates performing services on our behalf.

Your Health Information Rights

IV. As described

- Request that we restrict certain uses and disclosures of your health information; we are not, however, required to agree to a requested restriction.
- Request that we communicate with you by alternative means, such as making records available for pick-up, or mailing them to you at an alternative address, such as a P.O. Box. We will accommodate reasonable requests for such confidential communications.
- Request to review, or to receive a copy of, the health information about you that is maintained in our files and the files of our business associates. We reserve the right to charge a fee for the costs of copying, mailing or other supplies associated with your request. If we are unable to satisfy your request, we will tell you in writing the reason for the denial and your right, if any, to request a review of the decision.
- Request that we amend the health information about you that is maintained in our files and the files of our business associates. Your request must explain why you believe our records require amendment. If we are unable to satisfy your request, we will tell you in writing the reason for the denial and tell you how you may contest the decision, including your right to submit a statement disagreeing with the decision. This statement will be added to your records.
- Request a list of our disclosures of your health information. This list, known as an "accounting" for disclosures, will not include certain disclosures, such as those made for treatment, payment, or health care operations. We will provide you the accounting free of charge, however if you request more than one accounting in any 12 month period, we may impose a reasonable, cost-based fee for any subsequent request. Your request should indicate the period of time in which you are interested. We will be unable to provide you an accounting for any disclosures made before
- Request a paper copy of this Notice. In order to exercise any of your rights described above, you must submit a written request to our office. If you have questions about your rights, please speak with our contact person, available by phone or email during normal office hours.

To Request Information or file a Complaint

V. If you believe your privacy rights have been violated, you may file a written complaint by mailing it or delivering it to our contact privacy officer at 510-856-4800.

Revisions to this Notice

VI. We reserve the right to amend the terms of this Notice. If this Notice is revised, the amended terms shall apply to all health information that we maintain, including information about you collected or obtained before the effective date of the revised Notice. If the revisions reflect a material change to the use and disclosure of your information, your rights regarding such information, our legal duties, or other privacy practices described in the Notice, we will promptly distribute the revised Notice, post it in the waiting area of our offices, make copies available to our patients and others, and post it on our website.

I acknowledge that I have received a copy of the Notice of Privacy Practices of Castro Valley Open MRI. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

_____ _____

Patient Signature **Date**

CASTRO VALLEY
OPEN MRI

Consent for Treatment and Financial Agreement

A. **Consent for Treatment:** I am entering Castro Valley Open MRI for the purpose of medical and /or invasive treatment or diagnosis. I consent to my physician, consulting and/or referring physicians and their assistants and designees, and other facility personnel, to provide me with medical, diagnostic, or other treatment services judged necessary and/or appropriate by my physician. This includes my consent for such services as x-rays and laboratory tests, treatments or medication, monitoring and all other procedures or treatments that do not require my specific informed consent.

B. **General Acknowledgment:** I understand the practice of medicine is not an exact science. I understand that medical treatment and diagnosis may involve risk of injury. No guarantees have been made to me in the relations to the results of my examinations or treatments in the facility. I understand that it is my responsibility to follow instructions and make arrangements for follow-up care. I understand that I may review and obtain a copy of my medical records at my own expense, and that this review shall take place in the facility, during regular business hours.

C. **Assignment and Agreement to Pay:** I understand that I am responsible for payment for the services that I receive and guarantee payment for these services. I hereby assign to the facility and the physicians and professionals associated with the facility, for application to my bill for services all rights and claim for reimbursement under federal or state healthcare plan (including but not limited to Medicare or Medicaid), insurance policy, and managed care arrangement or any other similar third party payer arrangement that covers health care cost and for which payment may be available to cover that cost of the services provided me. I understand that I am responsible for any applicable co-payment, deductible, co-insurance and/or non-covered cost and charges at the time of my MRI services. I understand that not all insurance companies pay the usual and customary fees of the facility, the physician and/or the professionals associated with the facility. Therefore, when permitted by law and any outstanding balance will be my responsibility. I understand and agree that I am responsible for the cost of collection and/or reasonable attorney fees related to my account. I understand that my health information will be released to my insurers, payers, or other for billing purposes.

D. **Privacy Notice:** I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:
   a. Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.
   b. Obtain payment from third party payers.
   c. Conduct normal healthcare operations such as quality assessments and physician certification.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosure of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact the facility at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you agree then you are bound to abide by such restriction.

Patient Signature: _____ Date: _____/_____/_____

Patient History Questionnaire (MRI)

Patient Name:_____ Date: _____

Reason for Procedure:

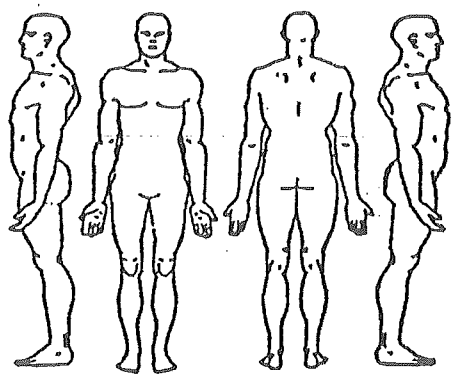
Please check any of the following symptoms that you are experiencing:

- ☐ Chest pain ☐ Headaches ☐ Nausea ☐ Hearing loss
- ☐ Abdominal pain ☐ Blackouts ☐ Blurred vision ☐ Ringing in ears
- ☐ Pelvic Pain ☐ Dizziness ☐ Memory loss ☐ Seizures
- ☐ Back pain ☐ Neck pain ☐ Unexpected weight loss
- ☐ Shoulder pain - (☐ Right/☐ Left) ☐ Numbness - (☐ Right side/☐ Left side)
- ☐ Leg pain - (☐ Right/☐ Left) ☐ Weakness - (☐ Right side/☐ Left side)
- ☐ Arm pain - (☐ Right/☐ Left) ☐ Other: _____

How and when did these symptoms occur (e.g., injury, just started, etc.)?

_____

_____



Please identify the location of any pain/numbness/lump

Medical History:

1. Do you have or have you had any of the following?
   - ☐ Cancer ☐ Heart disease ☐ Kidney/renal disease ☐ Multiple myeloma ☐ Hypertension
   - ☐ Seizures ☐ Sickle cell anemia ☐ Tumor, lump or mass ☐ Bleeding tendency ☐ Heart arrhythmia
   - ☐ Diabetes ☐ Congenital heart defect ☐ Glaucoma ☐ Stroke
   - ☐ Asthma, bronchitis or emphysema ☐ Other illness/disease: _____
2. Have you had any tests (MRI, CT, X-Ray, etc.) performed for the symptoms you are currently experiencing? ☐ Yes ☐ No
   If yes, please list the date, type and who performed the test: _____
   _____
3. Have you had any surgeries or therapies (e.g., radiation therapy, chemotherapy, etc.)? ☐ Yes ☐ No
   If yes, please list the date and type of surgery or therapy: _____
   _____
4. Are you currently taking any medications? ☐ Yes ☐ No
   If yes, please list all medications you are currently taking: _____
   _____
5. Do you have any allergies (e.g., medications, latex, food, etc). ☐ Yes ☐ No
   If yes, please list all medications you are currently taking:_____
   _____

I hereby certify that the above information is true and correct to the best of my knowledge.

_____ _____ _____

Patient or Legal Representative Signature | Print Name and Authority (if legal representative) | Date

Technologist Notes:_____

_____

_____

MRI SAFETY SCREENING QUESTIONNAIRE

Please indicate if you have any of the following:

Aneurysm clip(s)	☐ NO ☐ YES
Cardiac pacemaker	☐ NO ☐ YES
Implanted cardioverter defibrillator (ICD)	☐ NO ☐ YES
Electronic implant or device	☐ NO ☐ YES
Magnetically-activated implant or device	☐ NO ☐ YES
Neurostimulation system	☐ NO ☐ YES
Spinal cord stimulator	☐ NO ☐ YES
Internal electrodes or wires	☐ NO ☐ YES
Bone growth/bone fusion stimulator	☐ NO ☐ YES
Cochlear, otologic, or other ear implant	☐ NO ☐ YES
Insulin or other infusion pump	☐ NO ☐ YES
Implanted drug infusion device	☐ NO ☐ YES
Any type of prosthesis (eye, penile, etc.)	☐ NO ☐ YES
Heart valve prosthesis	☐ NO ☐ YES
Eyelid spring or wire	☐ NO ☐ YES
Artificial or prosthetic limb	☐ NO ☐ YES
Metallic stent, filter, or coil	☐ NO ☐ YES
Shunt (spinal or intraventricular)	☐ NO ☐ YES
Vascular access port and/or catheter	☐ NO ☐ YES
Radiation seed or implants	☐ NO ☐ YES
Swan-Ganz or thermodilution catheter	☐ NO ☐ YES
Medication patch (Nicotine, Nitroglycerine)	☐ NO ☐ YES
Any metallic fragment or foreign body	☐ NO ☐ YES
Wire mesh implant	☐ NO ☐ YES
Tissue expander (e.g., breast)	☐ NO ☐ YES
Surgical staples, clips, or metallic sutures	☐ NO ☐ YES
Joint replacement (hip, knee, etc.)	☐ NO ☐ YES
Bone/joint pin, screw, nail, wire, plate, etc.	☐ NO ☐ YES
IUD, diaphragm, or pessary	☐ NO ☐ YES
Dentures or partial plates	☐ NO ☐ YES
Tattoo or permanent makeup	☐ NO ☐ YES
Body piercing jewelry	☐ NO ☐ YES
Hearing aid *(Remove before entering MR system room)*	☐ NO ☐ YES
Other implant_____	☐ NO ☐ YES
Breathing problem or motion disorder	☐ NO ☐ YES
Claustrophobia	☐ NO ☐ YES
If female, are you pregnant?	☐ NO ☐ YES

I attest that the above information is correct to the best of my knowledge. I read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form and regarding the MR procedure that I am about to undergo.

PATIENT SIGNATURE

X_____

Date_____/_____/_____

TECHNOLOGIST SIGNATURE

X_____