Orthopedic Care Specialists

PATIENT CONSENT & ACKNOWLEDGEMENT FORM— MAGNETIC RESONANCE IMAGING (MRI)

This agreement allows Orthopedic Care Specialists to bill Medicare, or any other insurance company providing benefits on your behalf, for diagnostic services performed by Orthopedic Care Specialists. In Medicare assigned cases, Orthopedic Care Specialists agrees to accept the Medicare "allowable charge" as the full charge.

I understand that my signature authorizes release of information necessary to receive payment and that payment is to be made directly to Orthopedic Care Specialists on my behalf for all payable benefits on any and all insurance policies that may be in force.
I understand that I am responsible for the payment of any patient liability including, but not limited to, deductibles, coinsurance or non-covered charges.
I agree to provide full written documentation of any dispute regarding charges for services provided by Orthopedic Care Specialists within seven (7) days of the date the service is provided to:

Orthopedic Care Specialists
MRI
30 Roche Bros. Way
Easton, MA
Phone: (781) 573-1686
Fax: (781) 573-1696

Our **Notice of Privacy Practices (NPP)** describes how your Protected Health Information may be used or disclosed as well as your rights related to the privacy of your **Protected Health Information**. You are encouraged to review our **NPP** and to understand your rights and the provisions of our NPP. We welcome any NPP-related questions you may have.
My signature below acknowledges that I have been offered a printed copy of the Notice of Privacy Practices. My signature does not necessarily indicate that I have reviewed the content of the NPP or that I have accepted its provisions.

Magnetic Resonance Imaging (MRI) forms pictures of the body by positioning it within a magnetic field. Radio signals are transmitted into the tissues, and a computer records the "echoes" which return. The pattern of these echoes is made into a picture of the body's internal structure. Magnets may attract metal objects both within and outside of the body and cause malfunctions of electronic or mechanical implants.

My signature indicates that I have been informed that I <u>will be excluded</u> from undergoing and MRI scan if I have one or more of the following:

-Neuro-Pacemaker
-Cardiac Pacemaker
-Implanted Chemotherapy Pump
-Cochlear Implant

I have been informed that I <u>may be excluded</u> from undergoing an MRI scan due to the presence of one or more of the following conditions with respect to my body:

-Brain Aneurysm Clips (suspected)
-Dermal Treatment Patches
-Pregnancy
-"Body Jewelry"

My signature below indicates that I have been informed of the contraindications and possible risks associated with the prescribed scan, that a clinic representative has questioned me about my suitability for this scan and that all of my questions regarding this scan have been answered to my satisfaction.
I waive all claims for magnetic damage done to items left on my person during this scan (e.g wallet, watch, credit cards, etc.)
My signature below indicates that I authorize Orthopedic Care Specialists to perform the MRI scan.

_____ _____
Signature of Patient or Patient's Legal Representative — Date

_____ _____
Printed Name of Patient or Legal Representative (if applicable) — Relation to patient

Initials/Location Patient ID/MR#