



Oklahoma  
*Breast Care Center*

- Dr. written order \_\_\_\_\_
- Verbal order by: \_\_\_\_\_
- Ins. Co. precert/benefit
- Pt. given instructions  
On \_\_\_\_\_ By \_\_\_\_\_
- Confirmed Appt.

OBCC Comp # \_\_\_\_\_

OBCC File # \_\_\_\_\_

Date of Scan: \_\_\_\_\_

Apt. set by OBCC or \_\_\_\_\_

Apt. Time: \_\_\_\_\_

On date \_\_\_\_\_

Any record of patient having metal in the body \_\_\_\_\_

Patient Name:

\_\_\_\_\_  
(last) (first) (mi)

DOB: \_\_\_\_\_ Telephone: ( ) \_\_\_\_\_ ( ) \_\_\_\_\_  
(home) (work)

Date of Last MRI: \_\_\_\_\_

Breast Implants: Yes No Saline Silicone

Date of Last Mammogram: \_\_\_\_\_

Estimated Weight \_\_\_\_\_

Insurance Card on file: \_\_\_\_\_ Films: need / have

Do you have any kidney function problems/on dialysis? Yes No

Referring Physician: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_

Additional Dr. \_\_\_\_\_

|                            |       |        |        |             |
|----------------------------|-------|--------|--------|-------------|
| Indication for breast MRI: | V10.3 | V16.3  | 611.72 | 610.1       |
|                            | 174   | V43.82 | ADH    | Other _____ |

Valium to be given? Yes No

Time given \_\_\_\_\_ Amount given \_\_\_\_\_ By \_\_\_\_\_

Comments

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**MRI PRECERT and BENEFITS**

Patient: \_\_\_\_\_ Computer: \_\_\_\_\_ File: \_\_\_\_\_

DOB: \_\_\_\_\_ Proc. Date: \_\_\_\_\_ Insured ID #: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**BENEFITS:**

Date of Call: \_\_\_\_\_ Time: \_\_\_\_\_ Spoke to: \_\_\_\_\_

Eligible date of Service: \_\_\_\_\_ Currently in force: \_\_\_\_\_

What is the deductible: \_\_\_\_\_ Has it been met: \_\_\_\_\_ How much: \_\_\_\_\_

Is a Breast MRI a covered benefit? \_\_\_\_\_ Any exclusions \_\_\_\_\_

Are there limitations to the number of breast MRI in a year? \_\_\_\_\_

Can your verify coverage on DX \_\_\_\_\_ DX for MRI (code): \_\_\_\_\_

Is precert needed for Breast MRI: \_\_\_\_\_

Benefits are: \_\_\_\_\_ Co pay: \_\_\_\_\_

Is there a pre-existing clause on Breast? \_\_\_\_\_

We are a free standing Breast Center, are we covered by this plan? \_\_\_\_\_

**PRECERT:**

Date of Call: \_\_\_\_\_ Time: \_\_\_\_\_ Spoke to: \_\_\_\_\_

Precert By: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Authorization Number: \_\_\_\_\_ If requested DX given: \_\_\_\_\_

Reference #: \_\_\_\_\_ Clinical Fax \_\_\_\_\_



## **MRI WAIVER**

**Our radiologist and your physician have recommended an MRI for your complete breast care. The charge for this test is \$2189.00**

**Please be aware we have done our best to assist you by contacting your insurance carrier for precertification, benefits and have obtained a referral from your doctor. When verifying your information the insurance gives a “disclaimer” that benefits are not a guarantee of payment. Only after a claim is received will medical necessity be determined by your insurance.**

**Most insurance carriers recognize an MRI as a diagnostic procedure. Which refers to a patient with a “medical problem”. For example, cancer or implant integrity.**

**The new standard of care for patients with a family history or dense tissue is a dedicated breast MRI as these criteria puts you in a higher risk factor for breast cancer. IF you are scheduled for an MRI due to family history we have learned that most insurance carriers currently consider this a screening procedure.**

**I have read the above waiver and understand. I agree to be fully responsible for payment of this charge.**

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**Signature**

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**Date**



Oklahoma  
*Breast Care Center*

File No: \_\_\_\_\_

Date of MRI: \_\_\_\_\_

Computer No: \_\_\_\_\_

Phone Numbers:

Name: \_\_\_\_\_

Home: (\_\_\_\_) \_\_\_\_-\_\_\_\_\_

Address: \_\_\_\_\_

Office: (\_\_\_\_) \_\_\_\_-\_\_\_\_\_

\_\_\_\_\_ Zip \_\_\_\_\_

Social Security No: \_\_\_\_\_

Patient's Employer: \_\_\_\_\_

Insurance Company Name: \_\_\_\_\_

Name of Insured: \_\_\_\_\_

Insurance ID Number/Group or Plan No. \_\_\_\_\_

Insured's Employer and Phone No: \_\_\_\_\_

1. Sex \_\_\_\_ Female \_\_\_\_ Male

2. Date of Birth: \_\_\_\_\_

3. Age: \_\_\_\_\_

4. Height: \_\_\_\_ feet \_\_\_\_ inches

5. Weight: \_\_\_\_\_

6. Ethnic Origin: \_\_\_\_ White  
\_\_\_\_ Black  
\_\_\_\_ Native American Indian  
\_\_\_\_ Asian  
\_\_\_\_ Hispanic  
\_\_\_\_ Other Specify \_\_\_\_\_

7. Why are you having this examination (medical Problem)? \_\_\_\_\_

- |  | Yes | No  |
|--|-----|-----|
| 8. Have you ever had a MRI examination before?   | ___ | ___ |
| If yes, when, where, of what body part? _____<br>_____   |     |     |
| 9. Have you ever had a surgical operation or procedure of any kind?  | ___ | ___ |
| <b>If yes, list all prior surgeries and approximate dates:</b> _____<br>_____  |     |     |
| 10. Have you ever been injured by a metal object or foreign body (eg, bullet, BB, shrapnel)?                         | ___ | ___ |
| If yes, please describe: _____<br>_____  |     |     |
| 11. Have you ever had an injury from a metal object in your eye (metal slivers, metal shavings, other metal object)? | ___ | ___ |
| If yes, did you seek medical attention? _____  |     |     |
| If yes, describe what was found: _____   |     |     |
| 12. Do you have a history of kidney disease, asthma, or other allergic respiratory disease?                          | ___ | ___ |
| 13. Do you have any drug allergies?  | ___ | ___ |
| If yes, please list drugs: _____<br>_____  |     |     |
| 14. Have you ever received a contrast agent or X-ray dye used for MRI, CT, or other X-ray or study?                  | ___ | ___ |
| If yes, please describe: _____<br>_____  |     |     |
| 15. Date of last menstrual period or hysterectomy: _____   |     |     |
| 16. Are you pregnant or do you suspect you may be pregnant?  | ___ | ___ |
| 17. Are you breast-feeding?  | ___ | ___ |

18. Number of pregnancies \_\_\_\_\_

19. Number of live births \_\_\_\_\_

20. Age at first live birth \_\_\_\_\_

21. Did you breastfeed your babies:

\_\_\_ No \_\_\_ Some \_\_\_ All

22. Do you take birth control pills: \_\_\_\_\_ No \_\_\_\_\_ Past use \_\_\_\_\_ Yes, currently

23. Do you currently take hormones? \_\_\_\_\_ Yes \_\_\_\_\_ No

24. Do you take any postmenopausal medications? \_\_\_\_\_ No \_\_\_\_\_ Past use \_\_\_\_\_ Yes, currently

*If past use or yes, please indicate medication:* \_\_\_\_\_

25. Have you ever been diagnosed with any of the following? \_\_\_\_\_ *If yes, indicate which breast and age at diagnosis*

|   | Age |                               | Age |
|---|-----|-------------------------------|-----|
| R or L-Atypical Ductal Hyperplasia (ADH)            | ___ | R or L-Invasive breast cancer | ___ |
| R or L-Atypical Lobular Hyperplasia (ALH)           | ___ | Hodgkin's Disease             | ___ |
| R or L-Multiple papillomas                          | ___ | Positive for BRCA mutations   | ___ |
| R or L-Lobular Carcinoma In-Situ (LCIS)             | ___ | Ovarian cancer                | ___ |
| R or L-Non-Invasive Ductal Carcinoma In-Situ (DCIS) | ___ | DES Exposure                  | ___ |

26. Have you ever had any of the following procedures or treatment? \_\_\_\_\_ *If yes, indicate which breast and age at treatment.*

|                                | Age |                 | Age |
|--------------------------------|-----|-----------------|-----|
| R or L-Lumpectomy (For Cancer) | ___ | Chemotherapy    | ___ |
| R or L-Mastectomy              | ___ | Hormone Therapy | ___ |
| R or L-Radiation               | ___ | Tamoxifen       | ___ |
| R or L-Benign Biopsy           | ___ |                 |     |

27. Have any of your family members been diagnosed with either breast or ovarian cancer?

*If yes, indicate age at diagnosis:*

|                      | Breast Cancer<br>(Age at Diagnosis) | Ovarian Cancer<br>(Age at Diagnosis) |                      | Breast Cancer<br>(Age at Diagnosis) | Ovarian Cancer<br>(Age at Diagnosis) |
|----------------------|-------------------------------------|--------------------------------------|----------------------|-------------------------------------|--------------------------------------|
| Mother               | ___                                 | ___                                  | Paternal Aunt        | ___                                 | ___                                  |
| Sister               | ___                                 | ___                                  | Paternal Grandmother | ___                                 | ___                                  |
| Daughter             | ___                                 | ___                                  | Father               | ___                                 | ___                                  |
| Maternal Aunt        | ___                                 | ___                                  | Brother              | ___                                 | ___                                  |
| Maternal Grandmother | ___                                 | ___                                  |                      |                                     |                                      |

(Maternal is mother side, Paternal is father side)

28. Present breast abnormalities (please indicate which breast and check all that apply):

- |                            |       |  |       |
|----------------------------|-------|--|-------|
| R or L - Breast thickening | ___   | R or L - Fibrocystic                             | ___   |
| R or L - Breast Lump       | ___   | R or L - Implant integrity                       | ___   |
| R or L - Pain/Tenderness   | ___   | Cancer elsewhere                                 | _____ |
| R or L - Nipple discharge  | ___   | R or L - Follow up to suspicious mammogram/ultra |       |
| R or L - Nipple retraction | ___   | sound finding                                    | _____ |
| R or L - Other             | _____ |  |       |
- 

29. Primary Care physician:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_ Specialty \_\_\_\_\_

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30. Referring physician:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_ Specialty \_\_\_\_\_

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Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_ Specialty \_\_\_\_\_

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Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_ Specialty \_\_\_\_\_

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**MR Hazard Checklist**

The following items may be harmful to you during your MR scan or may interfere with the MR examination. You must provide a “yes” or “no” for every item. Please indicate if you have or have had any of the following:

| Yes | No  |  |
|-----|-----|--|
| ___ | ___ | Any type of electronic, mechanical, or magnetic implant<br>Type: _____   |
| ___ | ___ | Cardiac pacemaker  |
| ___ | ___ | Aneurysm clip  |
| ___ | ___ | Implanted cardiac defibrillator  |
| ___ | ___ | Neurostimulator  |
| ___ | ___ | Biostimulator<br>Type: _____   |
| ___ | ___ | Any type of internal electrodes or wires                                 |
| ___ | ___ | Cochlear implant   |
| ___ | ___ | Hearing aid  |
| ___ | ___ | Implanted drug pump (eg, insulin, Baclofen, chemotherapy, pain medicine) |
| ___ | ___ | Halo vest  |
| ___ | ___ | Spinal fixation device   |
| ___ | ___ | Spinal fusion procedure  |
| ___ | ___ | Any type of coil, filter, or stent<br>Type: _____                        |
| ___ | ___ | Any type of metal object (eg, shrapnel, bullet, BB)                      |
| ___ | ___ | Artificial heart valve   |
| ___ | ___ | Any type of ear implant  |
| ___ | ___ | Artificial eye   |
| ___ | ___ | Eyelid spring  |
| ___ | ___ | Any type of implant held in place by a magnet<br>Type: _____             |
| ___ | ___ | Any type of surgical clip or staple                                      |
| ___ | ___ | Any IV access port (eg, Broviac, Port-a-Cath, Hickman, Picc line)        |
| ___ | ___ | Medication patch (eg, nitroglycerine, nicotine)                          |
| ___ | ___ | Shunt  |
| ___ | ___ | Artificial limb or joint<br>What and where: _____                        |
| ___ | ___ | Tissue expander (eg, breast)   |
| ___ | ___ | Removable dentures, false teeth, or partial plate                        |
| ___ | ___ | Diaphragm, IUD, Pessary<br>Type: _____                                   |
| ___ | ___ | Surgical mesh<br>Location: _____   |
| ___ | ___ | Body piercing _____<br>Location: _____                                   |
| ___ | ___ | Wig, hair implants   |
| ___ | ___ | Tattoos or tattooed eyeliner   |
| ___ | ___ | Radiation seeds (eg, cancer treatment)                                   |
| ___ | ___ | Any implanted items (eg, pins, rods, screws, nails, plates, wires)       |
| ___ | ___ | Any hair accessories (eg, bobby pins, barrettes, clips)                  |
| ___ | ___ | Jewelry  |
| ___ | ___ | Any other type of implanted item<br>Type: _____                          |

**Instructions for the Patient**

1. You are required to use the headphones we supply during your MRI examination since the noise levels may affect your hearing.
  2. Remove all jewelry (eg, necklaces, pins, rings).
  3. Remove all hairpins, bobby pins, barrettes, clips, etc.
  4. Remove all dentures, false teeth, and partial dental plates.
  5. Remove hearing aids.
  6. Remove eyeglasses.
  7. Remove your watch, pager, cell phone, credit cards, bankcards, and all other cards with a magnetic strip.
  8. Remove body piercing objects.
- 

I attest that the above information is correct to the best of my knowledge. I have read and understand the entire contents of this form, and I have had the opportunity to ask questions regarding the information on this form.

**Patient signature:** \_\_\_\_\_

MD/RN/RT signature: \_\_\_\_\_

Date: \_\_\_\_\_



**MRI CONSENT FOR MEDICAL INJECTION**

Patient: \_\_\_\_\_ Date: \_\_\_\_\_

File No: \_\_\_\_\_ Computer No: \_\_\_\_\_

I hereby give permission for Oklahoma Breast Care Center Radiologist and their medical assistant that he/she might designate to administer oral valium and an injection of Gadoversetamide to the above named patient. The contrast agent is used to find abnormal vascularity (blood flow) in breast tissue.

We offer a low dose valium (5mg) to assist you in relaxing during the MRI. We require that you have a driver to assist you after taking this medication. If you take the valium with out a designated driver you also agree to hold the Oklahoma Breast Care Center harmless.

I have been informed of the purpose for the injection, and am aware of possible side effects and reactions, some of which include:

- |  |   |
|--|---|
| Local site reaction                    | Asthma Attack   |
| Discomfort at or around injection site | Fainting  |
| Rash                                   | Facial or tongue swelling                                     |
| Itching                                | Damage to kidneys, impaired vision or hearing                 |
| Hives                                  | Damage to nerve, blood vessel or muscle                       |
| Difficulty breathing                   | Severe Anaphylactic attack resulting in brain damage or death |

**I HAVE READ AND UNDERSTAND THE ABOVE CONSENT FORM, AND ALL QUESTIONS WERE ANSWERED IN A LANGUAGE THAT I UNDERSTOOD. ALL OF THE BLANKS WERE FILLED IN PRIOR TO MY SIGNATURE.**

**Signature of Patient** \_\_\_\_\_ **Date** \_\_\_\_\_

WHEN A PATIENT IS A MINOR OR UNABLE TO GIVE CONSENT:

**Signature of Person Authorized to**

**Consent for Patient** \_\_\_\_\_ **Date** \_\_\_\_\_

**Relationship to Patient** \_\_\_\_\_

**Witness** \_\_\_\_\_



File \_\_\_\_\_

**ACKNOWLEDGMENT OF RECEIPT OF INFORMATION**

My physician has recommended that I undergo a Magnetic Resonance Breast Imaging study, and has explained to me the basis for that recommendation. I understand that there are certain contraindications to my having this test. These contraindications include the presence of certain (metal) devices/equipment in my body.

I have been informed by a clinic representative that I must be excluded from undergoing a MRI study if one or more of the following conditions exist with respect my body:

- the presence of suspected presence of aneurysm clips
- the presence of metal (e.g. wires or clips) in other parts of my body
- pregnancy

I have been informed of the above contraindications and safeguards and have been questioned about the presence of internal or external metal in my body.

I authorize Oklahoma Breast Care Center to perform the Magnetic Resonance Breast Imaging Scan.

**Signed:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**\*\*A 48 hour notice is required to obtain copies of MRI films**



**INFORMED CONSENT**

- 1. I AUTHORIZE THE OKLAHOMA BREAST CARE CENTER (OBCC) TO RELEASE OR REQUEST COPIES OF MEDICAL RECORDS AND X-RAY PERTINENT TO THE COURSE OF MY EXAMINATION.**
- 2. I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT OF ALL CHARGES RESULTING FROM THIS VISIT.**
- 3. I AM AWARE THAT ANY DIAGNOSTIC STUDIES MAY BE SUBJECT TO MY DEDUCTIBLE AND/OR NOT COVERED AS DICTATED BY MY INSURANCE POLICY.**
- 4. IT IS THE POLICY OF OBCC THAT ANY CHARGES OVER 90 DAYS REQUIRE A MINIMAL MONTHLY PAYMENT, UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE.**
- 5. IF I ELECT TO HAVE MY INSURANCE FILED BY OBCC, I GIVE IRREVOCABLE AUTHORIZATION THAT THIS BE DONE WITH SIGNATURE ON FILE. A PHOTOSTATIC COPY WILL SERVE AS THE ORIGINAL.**
- 6. I AM AWARE THAT EFFECTIVE APRIL 14, 2003 I HAVE ACCESS TO THE PATIENT'S PRIVACY NOTICE ENFORCED BY OKLAHOMA BREAST CARE CENTER UPON REQUEST.**
- 7. I REQUEST A WRITTEN REMINDER FOR MY ANNUAL APPOINTMENT.**

\_\_\_\_\_  
PATIENT'S OR GUARDIAN'S SIGNATURE

DATE \_\_\_\_\_

**IF YOU HAVE REQUESTED FILMS TO BE SENT TO US FROM A PRIOR FACILITY, PLEASE NOTIFY THE RECEPTIONIST.**