DEMOGRAPHICS

PATIENT INFORMATION

Date	Last Name	First Name	Middle Initial
Physical Address		City	State	Zip
Mailing Address		City	State	Zip
Sex	Date of Birth	Social Security #	Home Phone	Cell Phone
Email Address	Employed By	City	State	Work Phone

IF PATIENT IS A MINOR, PARENT INFORMATION

Relationship to Patient	Last Name	First Name	Social Security #
Home Address	City	State	Zip	Home Phone
Employed By	City	State	Work Phone
Spouse Name	Employed By	Phone

HEALTH INSURANCE INFORMATION

Primary Insurance Company	Policyholder	Date of Birth	Self	Spouse	Child	Other
Policyholder Social Security #	Member ID #	Group #	Insurance Phone #
Secondary Insurance Company	Policyholder	Date of Birth	Self	Spouse	Child	Other
Policyholder Social Security #	Member ID #	Group #	Insurance Phone #

AUTO ACCIDENT/WORKERS COMPENSATION

Accident? Circle One Yes No	Date of Accident/Injury	Place of Accident:	Work	Auto	Home	School	Other:
Your Auto Insurance Company	Claim Number	Adjuster Name	Adjuster Phone #
Law Firm	Attorney Name	Paralegal Name	Attorney Phone #

EMERGENCY CONTACT/SECONDARY CONTACT

Name of Nearest Relative or Friend	Address	Phone
How did you hear about US MRI?		

DIAGNOSTIC CONSENT

This procedure, together with any additional or different related procedures that in the opinion of the supervising physician or radiologist may be indicated, will be performed on you by the technologist. U.S. MRI maintains personnel and facilities to assist your physician and technologist in their performance of various diagnostic procedures. These procedures may all involve risks, unsuccessful results, complications, injury, or even death from both known and unknown causes. No warranty or guarantee is made as to results.

You have the right to be informed of the risks as well as the nature of the procedure, the expected benefits or effects of such procedure, and the available methods of diagnostics and their risks and benefits. Except in cases of emergency, procedures are not performed until you have had the opportunity to receive this information and have given your consent. You have the right to consent or to refuse any proposed procedure at any time prior to its performance. By signing this document, you certify that your physician and/or technologist have fully advised you of these matters. You authorize U.S. MRI to transfer you to another health care facility should the onsite physician determine it to be necessary. In addition, you also consent to the release of your medical records to such facility or other doctors, if needed.

Your signature below certifies that you have read and understood the information.

Provided in this form, the procedure set forth will be adequately explained to you by your technologist; you will have the chance to ask questions, be given all the information you desire concerning the procedure, and you authorize and consent to the performance of the procedures.

Signature _____Date _____ Relationship _____

CT QUESTIONNAIRE

Please answer all questions to the best of your ability

Patient Name: _____

1. Have you ever had IV contrast before? **Yes** **No**
2. Have you had an allergic reaction to IV contrast? **Yes** **No**
3. Have you had an allergic reaction to iodine? **Yes** **No**
4. Please list any allergies to medications or drugs: _____
5. Do you have a history of the following conditions?
   - High Blood Pressure **Yes** **No**
   - Diabetes **Yes** **No**
   - Heart Disease **Yes** **No**
   - Kidney Disease **Yes** **No**
   - Asthma/Other Lung Disease **Yes** **No**
   - Blood Clotting Disorder **Yes** **No**
   - Hepatitis B or C **Yes** **No**
   - Are you/ Have you ever been a smoker **Yes** **No**
   - Other: _____
6. Do you take Glucophage, Metformin, Glucovance, or Avandamet? **Yes** **No**
7. Are you taking any blood thinners? **Yes** **No**
8. Do you or your family have a history of cancer? **Yes** **No** Explain: _____
9. Do you have a powerport that is accessible? **Yes** **No**
10. Last time you ate or drank anything other than the CT Prep: _____

(For Females Only)

The radiation used in CT may be harmful to an unborn child. To help prevent the accidental irradiation of an unrecognized pregnancy, and in accordance with the national standards, we require the following information from female patients of childbearing age. If any of the information indicated even the remote possibility of pregnancy, your referring physician will be asked to order a urine or serum pregnancy test prior to any imaging.

Please answer the following questions:

1. Are you, or is it possible that you might be pregnant? **Yes** **No**
2. If you are not currently on birth control, have you had sexual activity since your last menstrual period that may put you at risk of pregnancy? **Yes** **No**
3. Name of birth control? _____
4. Date of last menstrual period: _____

Disclosure: The contrast substance is considered quite safe. However, an injection carries a slight risk, including injury to a vein, infection, or reaction to material being injected. Physicians and technologists at U.S. MRI are trained to treat reactions to contrast material. Most reactions are quite mild, consisting of sneezing or hives. Serious reactions are uncommon.

Patients have any of the following are at higher risk: already had a moderate or severe allergic-type reaction to contrast material, allergies, asthma or hayfever, diabetes, kidney or heart disease and multiple myeloma.

***Warning:** Use of Glucophage, Metformin, Glucovance, or Avandamet oral medications for diabetes, must be discontinued at the time of procedure. These drugs should not be taken for at least 48 hours following your procedure and until your doctor ensures your kidney function is normal.

If you have any questions, please ask the technologist performing your exam. I hereby consent to the above described procedure to be performed by U.S. MRI. I have read the above information, filled it out as accurate as possible, and my questions have been answered.

Patient Signature: _____ Date: _____ Time: _____

Relationship to patient: _____ Witness: _____

SCREENING FORM

Date: _____

Name: _____

Current Weight: _____ lbs. Height: _____

What are your symptoms? _____

_____

List any movements/positions that increase symptoms:

_____

_____

Was this the result of an injury? **Yes No**

If yes: Date of injury: _____

Was this work related? **Yes No**

Was this due to a motor vehicle accident? **Yes No**

Please describe how you were injured: _____

_____

Have you had surgery/injections on the affected area?

Yes No

List surgeries/injections and dates below:

Surgery/Injection	Date
_____	_____
_____	_____

Have you had any previous imaging for this problem?

Yes No

When? _____

Where? _____

Have you felt a lump in the area we are scanning?

Yes No

Does your family have a history of cancer?

Yes No

Are you diabetic?

Yes No

(Contrast Patients Only)

As part of your examination, your physician may deem it necessary to give you an injection of a contrast agent containing Isoview 370 contrast. This injection may help in more accurately diagnosing your condition. Although Isoview 370 contrast agents have been used safely in millions of cases, minor reactions (principally headache, nausea, or hives) may occur.

Have you ever had a reaction to Iodine-based contrast?

Yes No

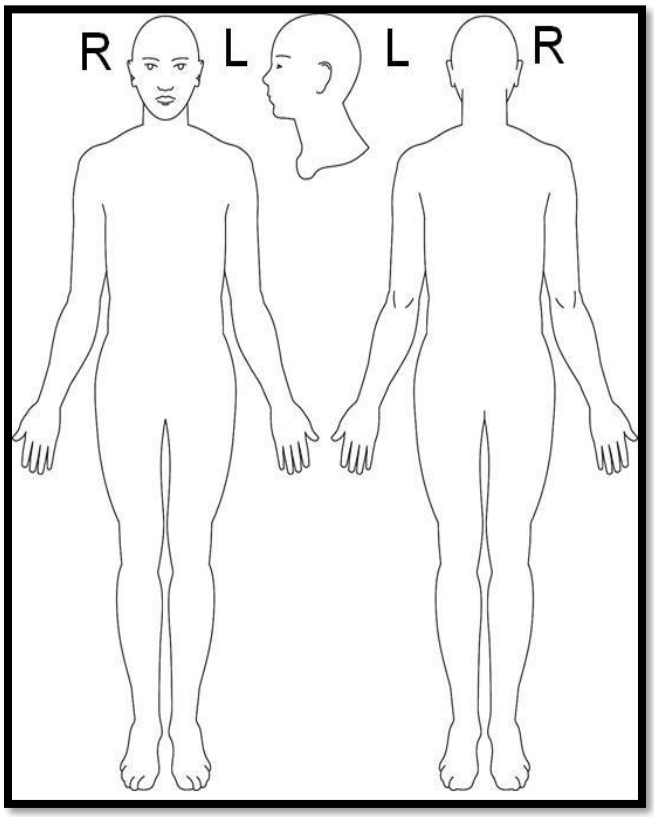
I have been informed above of any risks and/or side effects with having Isoview 370 contrast. I understand fully and all my questions have been answered.

Initials: _____

Symptoms Chart

(1) Circle where you have pain

(2) Shade where you have numbness/weakness



Mark all that apply to you:

If any of these apply, please talk to radiology technologist.

- ☐ Insulin or infusion pump
- ☐ Renal insufficiency
- ☐ Epilepsy / history of seizures
- ☐ Prosthetic device
- ☐ Shrapnel / bullets / BB's
- ☐ Metal worker
- ☐ Dentures (Please remove prior to scan)
- ☐ Hearing aids (Please remove prior to scan)
- ☐ Artificial limbs or joints
- ☐ Red blood cell disorder
- ☐ Rods, screws, plates, etc.
- ☐ **None**
- ☐ Any other surgically implanted device or objects:

  _____

Signature: _____

Date: _____ Relationship: _____

HIPAA AUTHORIZATION FORM

Authorization for Use or Disclosure of Protected Health Information
Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

1. **Authorization**

I authorize the following individuals to receive my protected health information, if requested by me:

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

*Referring physician for today's visit will automatically receive the radiology results and does not need to be listed above.

☐ **Check this box if you do not wish to authorize anyone to have access to your health information.**

2. **Effective Period**

This authorization for release of information is valid for one year from the date of service unless stated below:

☐ _____ to _____

3. **Related Visits**

Please mark the box below in which you would like this authorization to apply to:

☐ Today's visit only

☐ All past, present, and future periods

4. This medical information may be used by the person(s) I authorize to receive this information for medical treatment or consultation, billing, or claims payment, or other purposes as I may direct

5. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

6. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

7. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

8. I understand that if I request my PHI to be emailed, that I accept the security risks that may exist for my PHI while it is in transit.

Signature _____ Date _____ Relationship _____

Printed Name _____

FINANCIAL POLICY

Patient Name _____

It is our office policy to inform you of our patient payment procedure. SLMRI/U.S. MRI bills insurance as a courtesy. The contract you have with your insurance is between you and your insurance carrier. That insurance contract is not between your carrier and SLMRI/U.S. MRI. If your services are provided through a lien, you are ultimately responsible if the attorney withdraws.

Please carefully review the sections below.

1. Health Insurance
   Please Note: Deductibles, copays, and coinsurances cannot be determined until your health insurance has received and processed the claim. We cannot guarantee that our estimate is the exact amount that you will owe, but we do our best, based on our knowledge, to provide you with an estimate. Due to policy provisions in your contract with your insurance carrier, we are obligated to collect all patient responsibility balances. You are responsible for deductibles, copays, noncovered services, coinsurance and items considered "not a covered benefit" by your insurance company. Any balance unpaid after 90 days from the date of services were rendered will be considered "delinquent". All delinquent accounts will be charged an interest rate of 1.5% per month (18% annum). If you or your insurance carrier make payments exceeding your balance, reimbursement will be remitted. If payment cannot be made at each visit, notify the account coordinator so that other arrangements can be made. It is the responsibility of the patient to know their insurance plan. If you have given us erroneous information, you will be responsible for the balance.
2. Workers Compensation Patient
   As a worker's compensation patient, you may be covered by insurance if your injury is reported at work and verified with your employer. Be sure to inform the office personnel that your injury resulted during employment. Patient is ultimately responsible for the balance. It is patient responsibility to give us correct information. We cannot place a lien on a worker's compensation case.
3. Personal Injury
   If you are a personal-injury patient, our office will bill the appropriate insurance company. Third-party companies cannot be billed. If we are unable to obtain payment, the charges for the services rendered will be your responsibility. Please give all information needed for billing at time of service. Patient is ultimately responsible for balance.
4. Return Check Charges
   A return check handling charge of 25.00 will be applied to all return checks.
5. Cash Pay
   Discounted cash pay prices are offered to patients with no insurance or a high deductible. We offer these discounts as a courtesy to help patients afford such services. If you are offered a cash price, you have waived the right to us of billing any insurance regarding this service. If no payments are made on the account after 90 days, the account will be sent to collections for the full price of the MRI plus collection fees.

In the event any balance is not paid as agreed, the undersigned agrees to pay all collection costs. In the event of a lawsuit to collect the unpaid balance, the undersigned further agrees to pay court costs and reasonable attorney fees. You agree, for us to service your account or to collect any amounts you may owe, we may contact you by telephone at any phone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or e-mails, using any email address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

If you have additional questions or concerns upon reading these terms, please ask our office personnel.

I have read this disclosure and agree to terms listed above.

Signature _____ Date _____ Relationship _____

Witness _____