RESILIENCE IMAGING REGISTRATION INFORMATION

## PATIENT INFORMATION (PLEASE USE FULL LEGAL NAME)

Last:_____ First:_____MI:_____Sex: _____

DOB:_____ SSN# _____ Marital Status:_____ Home Phone: _____

Address: _____ Cell Phone: _____

City:_____State:_____Zip:_____

Employer:_____Work Phone: _____

Emergency Contact Name:_____Emergency Contact Phone #: _____

## RESPONSIBLE PARTY INFORMATION

Name:_____Relationship:_____Phone:_____

Address:_____ DOB_____SSN#:_____

Employer: _____Work Phone #_____

## INSURANCE INFORMATION

On the job injury: Yes / No Motor Vehicle Accident: Yes / No Injury Date: _____

**Primary Insurance**

Insurance Company:_____Policy #:_____Group Number: _____

Policy Holder Name: _____Policy Holder DOB: _____

Adjuster Name / Phone #: _____

**Secondary Insurance**

Insurance Company:_____Policy #:_____Group Number: _____

Policy Holder Name: _____Policy Holder DOB: _____

## RELEASE OF INFORMATION AND PAYMENT AUTHORIZATION

I authorize the release of information necessary to process this claim and assign benefits payable for services directly to Resilience Imaging. I authorize the release of any medical information necessary for treatment by my current or future physician or healthcare provider.

I authorize Resilience Imaging to release to my insurance company any medical information which may be necessary to process my insurance claim. I understand that in the event my insurance company denies this claim I may be held financially responsible for all charges.

I acknowledge that I have read and had the opportunity to receive a copy of Resilience Imaging's Privacy Notice.

Printed Name: _____

Signature: _____ Date: _____

RESILIENCE IMAGING

# Patient Authorization

## *Section I : Receipt Acknowledgement for the Notice of Privacy Practices*

I,_____have been made aware of the notice of Privacy Practices for Resilience Imaging. I understand that this notice states how Resilience Imaging may use and disclose my Protected Health Information ("PHI.")

I UNDERSTAND THAT A COPY OF THIS NOTICE IS AVAILABLE UPON REQUEST.

_____*Initial*

## *Section II: Consent for Treatment*

I authorize Resilience Imaging, to perform all exams, tests, procedures, injections and any other care deemed necessary or advisable for the diagnosis and treatment of my medical condition(s.)

_____*Initial*

## *Section III: Consent for Release & Acquisition of Medical Records*

In order to provide the most accurate reading of my current studies and to assure that I am receiving the highest quality of care, I consent to Resilience Imaging obtaining any of my previous images, radiology reports, pathology reports, or results of surgical intervention for comparison to my current studies and to track abnormal results. For the same purpose, Resilience Imaging may release my studies performed at a Resilience Imaging facility to my treating physicians and medical facilities, upon their request.

In order for Resilience Imaging to obtain and release my records in a timely manner, I authorize Resilience Imaging to convey my records and images by Certified Mail, Courier or Electronic Transmission.

*Initial*

## *Section IV: Release of Records to a Designated Third-Party*

In addition to my treating physicians and medical facilities, I authorize Resilience Imaging to release my records and images to the following individuals. (This should include **friends or family members** responsible for picking up your records when you are unable to do so.) PLEASE PRINT

Name: _____ Phone: _____

Name: _____ Phone: _____

_____*Initial*

## *Patient Signature:*

By signing below I am verifying that I have read each of the four sections on this page. I understand each section and consent to and agree with the information stated in each section.

_____ _____

**Patient / Legal Representative Signature** **Date**

_____ _____

**Patient's Printed Name** **Date**

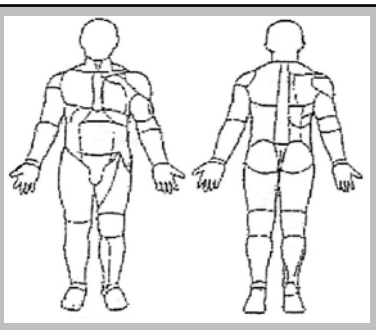
RESILIENCE IMAGING

# Patient MRI/CT History Form

**Patient Name: _____ Date of Birth:_____**

| **Do you have any of the following items in your body?** | | | |
|---|---|---|---|
| Pacemaker / Defibrillator /Pacer Wires | YES | NO | |
| Ear Surgery/Cochlear Implant/Hearing Aids | YES | NO | |
| Brain Aneurysm Clips or Coils | YES | NO | |
| Any metal / foreign body removed from eyes | YES | NO | |
| Gun Shot Wound, Shrapnel, or Metal Fragments in body | YES | NO | |
| Implanted electrical devices Pain Pump/Insulin Pump | YES | NO | |
| Any other Implants | YES | NO | |
| Tattoos/Permanent Make-up/Body Piercings | YES | NO | |
| Colonoscopy/Endoscopy/Gastric Scope | YES | NO | If Yes, Date performed:_____ |
| *If YES, were clips placed in the GI Tract* | YES | NO | If Yes, Date performed:_____ |
| Brain Shunt | YES | NO | |
| Neurostimulators | YES | NO | |
| Stents in Heart /Legs / Kidneys /Other | YES | NO | |
| Dentures held in with magnets | YES | NO | |
| Any Transdermal Patches (medication patches) | YES | NO | (If Yes, needs to be removed prior to MRI) |

| **Do you have any History of the following?** | | |
|---|---|---|
| History of Myeloma / Multiple Myeloma? | YES | NO |
| Liver transplant or failure? | YES | NO |
| Are you Diabetic (type I or II)? | YES | NO |
| Asthma? | YES | NO |
| History of KIDNEY FAILURE, Kidney surgery, or Kidney Cancer? | YES | NO |
| Are you currently on dialysis / blood transfusion? | YES | NO |
| Do you take any medication for hypertension (high blood pressure)? | YES | NO |
| Heart Failure / Heart Surgery | YES | NO |
| Are you on any blood thinners? | YES | NO |
| Are you taking any of the following: (*If yes, Circle Medication below*) Glucophage, Glucovance, Metformin, Actos Plus Met, Avandamet, Fortamet, Metaglip, Glumetza, Riomet, or Janumet? | YES | NO |
| **FOR SPINE EXAMS**: Any Leg or Arm Pain? | YES | NO |



**Please Mark Area of Pain**

| ***FEMALE PATIENTS ONLY:*** | | | | |
|---|---|---|---|---|
| Any possibility of being pregnant? | YES | NO | Patient Initials_____ | Tech Initials_____ |
| Are you breast feeding? | YES | NO | Patient Initials_____ | Tech Initials_____ |

Have you ever had an Injection of Contrast? YES NO

*If Yes, Did you experience an allergic reaction to Contrast* (***Please Explain***) _____

List drug allergies: _____

List of other Medications that you are currently taking: _____

Current Weight: _____

Please list previous surgeries: _____

**Signature of Patient/guardian:_____ Date___/___/_____**

**Technologist/Witness Signature: _____ Date:___/___/_____**

RESILIENCE IMAGING

# INFORMED CONSENT FOR CT SCAN
# WITH OR WITHOUT CONTRAST INJECTION

**PATIENT NAME:**_____

**IF YOU ARE PREGNANT OR THINK THAT YOU MAY BE PREGNANT, PLEASE INFORM THE FACILITY PERSONNEL AT ONCE.**

Your physician has requested that we perform a computerized tomography scan (CT) to obtain additional information. This is a diagnostic test that uses x-ray and a computer to produce images of internal body parts.

As part of your examination, we may need to inject you with a contrast solution containing iodine. This clear, colorless liquid is removed from your body by your kidneys and will not alter the appearance of your urine. It will show up on the images to provide important diagnostic information.

Soon after the injection you may experience a metallic taste and a warm sensation. You may feel some nausea. These feelings last only a short time.

Occasionally, minor allergic reactions occur in the form of itching, sneezing, hives, swelling of the eyes or wheezing. These symptoms may require treatment with medication we have on hand. It is very important that you inform the technologist if you experience any of the conditions mentioned in this form.

Rarely, a more serious reaction will occur. Even though it is extremely rare, medical statistics indicate that a fatality may occur from the injection of contrast. If you have had a reaction to a contrast injection previously or a history of asthma or other allergic conditions, any history of diabetes or any kidney disorder, anemia or sickle cell anemia, if you are taking Glucophage, are pregnant or breast feeding, you MUST inform the technologist.

The benefit of this exam is to assist your physician with making a diagnosis. There may be other imaging alternatives, however, your physician believes the CT scan to be the best diagnostic test for you after evaluating your symptoms and medical condition.

By my signature below, I hereby certify that I have fully read this consent, had it explained to me or have had it read to me. I have been given an opportunity to ask questions about my condition, alternative forms of treatment, the procedures to be used, and the risks and hazards involved. I understand its contents and have sufficient information to give this informed consent.

_____DATE: _____
Patient/Parent/Legal Guardian Signature

_____DATE:_____
Technologist Signature