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**

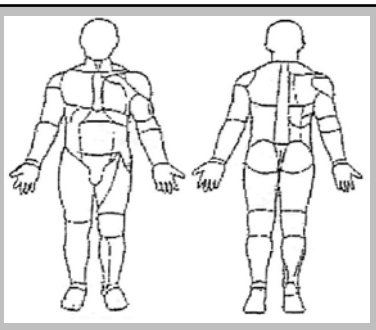
RESILIENCE IMAGING

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
MRI WITH OR WITHOUT CONTRAST INJECTION

PATIENT NAME:_____

I, the undersigned, being either the patient named above or legally authorized representative of the patient named above, do hereby consent to the performance of medical diagnostic and imaging procedures on the terms and conditions more fully set out below. I understand that I have the right to be informed about the diagnostic imaging procedure being used so that I may make the decision whether or not to undergo the procedure.

1. Consent to Imaging Procedure: Your attending physician believes it beneficial for you to undergo a diagnostic imaging procedure known as magnetic resonance imaging (MRI) to obtain additional information that may aid in diagnosing and treating your medical condition. It has been explained to me that MRI does not use x-rays or radiation. Instead a magnetic field and radio waves are used to create an image of internal body structures. MRI is a painless procedure that only requires that you lie quietly on a padded table that gently glides you into the magnet. While the scanner is performing your scan, you will hear some humming and thumping sounds. These are normal and should not worry you. In some cases, a contrast agent may be injected into your vein in order to give a clearer image of the area being examined. The MRI study may be conducted without the injection of contrast, but the images may not be as helpful to the radiologist and your physician. Inform the technologist if you wish to refuse the contrast injection.

2. Because of the magnetic field and radio frequencies, people with a heart pacemaker, brain aneurysm clips, and some implanted metallic or electrical devices should not have an MRI. It is important that you inform the technologist if you have any of these metallic appliances. Please inform the technologist if you are pregnant or think that you may be pregnant.

3. Potential Risks: Anytime an injection is given there is the potential for bruising or swelling at the injection site. Occasionally, minor allergic reactions occur in the form of itching, sneezing, hives, swelling of the eyes, wheezing or nausea. These symptoms may require treatment with medication we have at hand. Rarely, a more serious reaction will occur. A radiologist will evaluate the situation and determine if additional medical treatment is necessary. Even though it is rare, medical statistics indicated that a fatality might occur from the injection of contrast. If you have had a reaction to a sickle cell anemia or kidney disorder, are pregnant or breast feeding, you MUST inform the technologist.

4. 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 MRI 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, and 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