Patient Name_____ Arrival Time _____ am/pm

Sex_____Birthdate_____Age_____Weight_____

Social Security #_____

Patient Address_____

City_____State_____Zip_____

Home Phone_____ Cell Phone _____Work Phone_____

Email address _____

Referring Physician_____

Follow up appointment scheduled: Yes/No Date _____ Time _____

Health Insurance Company _____

Person Insured_____Relationship_____

Insured's Birthdate_____ Insured Social Security #_____

Policy # _____ Group #_____

Employer _____ Employer Phone _____

Employer Address _____

Victim of a violent crime? ___ (Ask the front desk if you are eligible for compensation)

X_____ (please initial) I authorize this facility to release any information or films which were acquired in the course of my examination or treatment. Written reports generated from your visit will be provided to your referring physician.

X_____ (please initial) I understand that this office bills insurance as a courtesy and that payment of these services are my responsibility. I permit the insurance company to make payment directly to Prime Diagnostic Imaging for services rendered. Also to appeal any claims to my insurance on my behalf. This does not apply to TWCC guidelines.

Signature_____Date_____

Patient History and Screening Form

Please read and answer each question carefully, as it pertains to you and the test you are having today.

Section I MRI patients only

	Yes	No
Cardiac (Heart) Pacemaker?	_____	_____
Heart disease or arrhythmias?	_____	_____
Other heart surgery, stents or valve?	_____	_____
Neuro-stimulator (Tens Unit) other implanted electrodes, pumps, or devices?	_____	_____
Brain surgery or aneurysm clip?	_____	_____
Other vascular surgery ?	_____	_____
War injury or gunshot wound?	_____	_____
Metal fragments in eye or other body parts that had to be removed?		
Eye Surgery or Prosthetic (i.e. Buckle,Cataract, Implants)	_____	_____
Joint and limb replacement metal rod, pin, screw or other orthopedic device?	_____	_____
Middle ear or Orbital prosthesis?	_____	_____
Hearing aid or dentures?	_____	_____
Currently wearing medication/nicotine patch?	_____	_____
Any renal/kidney failure or disease?	_____	_____
Asthma or other lung disease?	_____	_____
High Blood Pressure?	_____	_____
Have you ever had cancer or radiation therapy? If so, When?_____	_____	_____
Tattoos, body piercing or permanent make up?	_____	_____

List previous surgeries_____

Have you had an allergic reaction to contrast injected for MRI or CAT scan? _____

Section II

	Yes	No
FEMALE PATIENTS (Ages 12-55)		
Is there any possibility of pregnancy?	_____	_____
Do you have an IUD?	_____	_____
Are you breast-feeding?	_____	_____

Date of last menstrual cycle _____

I understand that radiation exposure can be harmful to a fetus and understand the risks involved if I am pregnant at this time.

Please sign _____ Date_____

Section III

Please describe your medical reason and symptoms for having this examination.

_____

_____

Date of injury_____ Length of symptoms_____

Have you had a previous MRI, CT, or X-rays related to this problem?_____ If so where and when?_____

PREGNANCY STATUS INFORMATION

In order to protect any unborn infant from unnecessary exposure to radiation, Prime Diagnostic Imaging requests all women of childbearing age (approximately 12 to 50 years of age) to complete this survey form. If you have any reason to believe you might be pregnant, we want to know that before any test involving radiation is performed. This information is not made available outside this department, but will be retained for your records in our department.

Name: _____
Last First Middle/Maiden

Age: _____

Are you pregnant: Yes_____ No_____ Maybe_____

Have you had a hysterectomy or tubal ligation? _____
If so, date of procedure: _____

If no, are you or your partner using any of the birth control methods listed below? Yes_____ No_____

Please check the method used:
_____Birth control pills _____ IUD
_____Husband vasectomy _____ Sponge
_____Abstinence/Inactive
_____Other,
please specify_____

How long have you used this method? _____ Months/Years

First day of your last menstrual period _____/_____/_____
Mo Day Year

Was it normal (if not, refer to M.D.) Yes/No Flow _____ # days_____

I have read and understand the above information and give my authorization for xray or Nuclear Medicine procedures.

_____
Patient Signature **Date**

_____
Witness

INFORMED CONSENT FOR CONTRAST
(MRI/CT/NUCLEAR MEDICINE) ONLY

As the patient you have the right to be informed about your condition and the recommended surgical, medical or diagnostic procedure your physician has ordered. It is your decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm, it is to educate you so you can make a decision to continue with your procedure.

Your physician has requested that we perform a study that requires the use of a contrast agent to better visualize the anatomy. If you have previously had a reaction to a contrast injection, such as hives, severe itching, shortness of breath and/or significant reaction requiring hospitalization, a history of allergic conditions and or asthma, any history of anemia, sickle cell anemia, kidney disorder, or are pregnant or breast feeding you MUST inform the technologist.

The following complications are possible any time an injection is given: Pain, bleeding, swelling or bruising at the injection site. Exams requiring contrast may result in a mild headache, nausea, itching or other vague symptoms for a short time after the injection. Other reactions may include hives, shortness of breath or difficult in swallowing. There have been rare instances of death after the administration of the contrast agent. It is **VERY** important that you inform the technologist if you experience any of the conditions mentioned in this form.

Contrast History – Any personal history of:	Yes	No
Immuno Compromised Disease (AIDS, HIV, HEP-C, etc.)	____	____
Do you have diabetes?	____	____
-If yes, are you on Metformin or Glucophage?	____	____
Seizures/Headaches/Dizziness/Stroke	____	____
Allergic Respiratory Disease/Asthma	____	____
Kidney/Bladder Disease	____	____
Liver Disorder	____	____
High Blood Pressure	____	____
Are you pregnant or breastfeeding?	____	____

Please list all allergies: _____

_____

I have answered these questions to the best of my knowledge and understand the information presented to me:

Patient Signature_____Date_____

Witness Signature_____

This section to be filled out by the Technician/EMT

_____ CC of Optimark with a _____ Ga @ _____ X _____
Time # of Punctures
@ _____ Lot # _____ Expiration Date _____
Injection Site

Physician providing contrast coverage: _____
Contrast reaction: _____Yes____No
Instructions for contrast reaction given: _____Yes____No
Tech/EMT Signature: _____ Date: _____

BENEFIT ASSIGNMENT RECORD RELEASE PAYMENT AGREEMENT

This agreement is entered into this date by and between _____ hereinafter "Patient" and Prime Diagnostic Imaging, JTP Diagnostics, Foundation Physicians Group, Silverstar, Cellular Medicine Solutions, Lakepointe Radiology and MT Med hereinafter "Provider". Whereas Patient desires to receive healthcare services from Provider and desires to assign certain rights and benefits to Provider as an inducement to cause Provider to wait for payment of such benefits, it is hereby agreed:

SECTION 1. Patient assigns to Provider any and all benefits payable by Patient's insurance or healthcare plan(s) as a result of charges incurred by Patient for services rendered by Provider. Patient also assigns to Provider any and all contractual rights Patient has against any insurance company, healthcare benefit plan or any other party contractually liable to Patient for payment of healthcare costs incurred by Patient as a result of services rendered by Provider. This assignment of benefits and contractual rights to those benefits shall not exceed the total amount of charges incurred by patient for services rendered by Provider. Patient agrees that payment for services rendered by Provider is due upon receipt of said services and Provider's acceptance of patient assignment of benefits is a convenience to Patient and that Provider may revoke this assignment at any time.

SECTION 2. Patient thereby directs all insurers and other persons responsible for Patient's healthcare costs to make all payment for the healthcare services rendered by Provider directly to Provider.

SECTION 3. Patient agrees to waive any applicable statute of limitations which may at any time interfere with Provider's right to collect for services rendered to Patient.

SECTION 4. Patient agrees that in the event Patient receives any check, draft or other payment subject to this Agreement, patient will act as a fiduciary agent for Provider and will immediately deliver said check, draft or payment to Provider. Provider agrees to apply the proceeds from the check, draft or payment to Patient's debt for services rendered.

SECTION 5. A copy of this document shall be as binding as the document bearing original signatures. At the time each claim is submitted, a copy of the claim will be stored for safekeeping in Patient's file and may be picked up by the Patient/insured at any time or will, upon request by the Patient/insured or be mailed to a designated address.

SECTION 6. Patient agrees to be responsible for any deductibles or co-payments required by the terms of any applicable insurance or healthcare plan. Patient further agrees to pay for any services not covered by Patient's insurance or healthcare plan. A refund, if any, will be calculated upon receipt of payment from your insurance company.

SECTION 7. In the event that any Section or provision of this Agreement is legally void, invalid or unenforceable, all other sections and provisions of this Agreement shall remain in full force and effect.

SECTION 8. Provider participates/contracts with many, but not all insurance companies. Provider can be determined dependent on the type of service provided. Contracts are not all the same and certain services may not be covered depending on your benefits. Whether provider participates with an insurance company or not, you must pay your copayment, coinsurance and/or remaining deductible at the time of service. Imaging services may be billed globally or split, technical and professional. You may receive one or two bills. Pain procedures may be billed by up to three providers, physician, facility, and anesthesiology.

IN WITNESS THEREOF, this agreement has been explained to the (patient's) satisfaction and having due knowledge and understanding entered into the day and year set forth below.

Patient	**Date**
Guardian (If patient is a minor)	**Date**
Witness	**Date**

Acknowledgement of Receipt of
Notice of Privacy Practices

I have received the Notice of Privacy Practices of Prime Imaging Partners, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document for my records.

_____ _____

Signature of Patient **Date**
Or Personal Representative

_____

Printed Name of Above Signature

_____

Relation to Patient if Signed by Representative

_____

Prime Diagnostic Witness

PRiME Diagnostic Imaging

12840 Hillcrest Plaza Dr.,
Suite E100,
Dallas, TX 75230
Phone (214)341-8770
Fax (214) 341-1603

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient:_____

Social Security Number: _____ DOB:_____

Release to:

Name and address of recipient to whom information is to be released if other than PDI:

☐Any Requesting Physician ☐Insurance Co. ☐Attorney ☐Hospital ☐Other (Specify):

GENERAL AUTHORIZATION: I authorize the above named healthcare provider to release the information specified below to the organization or individual named on this request. I understand that my physician(s) may be notified about this request. I agree to pay the facility's reasonable charge for copying any documents, and I understand that the facility may require a reasonable time to make any copies.

INFORMATION REQUESTED:

☐Radiology Reports

☐Radiology Films

☐Clincal Reports

CONDITIONS AND DATES OF CARE COVERED:

☐All exams at this facility provided as of the date of my signature.

☐Limited to exam dates and/or conditions described below:

_____
_____

PURPOSE(S) OR NEEDS FOR WHICH INFORMATION IS TO BE USED:

☐Continuing Medical Care ☐Insurance Request ☐Other (Specify):
_____

EXPIRATION OR REVOCATION OF AUTHORIZATION: I understand that I may revoke this authorization in writing at any time, except to the extent that action has already been taken to comply with it. I understand that this authorization will not apply to admission or care provided after the date of my signature. Even if I do not revoke this authorization in writing, this authorization will automatically expire (initial one):

_____ On the following date: _____

_____ 180 days from the date of my signature

►Sign Here _____
Signature of Patient or Designated Representative Date