PRiME Diagnostic Imaging

GENERAL INFORMATION

Patient Name _____ Social Security # _____

Sex _____ DOB _____ Age _____ Weight _____ Height _____

Patient Address _____

City _____ State _____ Zip _____

Main Phone _____ Alternate Phone _____

Email address _____

Emergency Contact _____ Phone _____ Relationship _____

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 _____

X_____ (please initial) I authorize this facility to release any information or images 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 facilities for services rendered. Also to appeal any claims to my insurance on my behalf. This does not apply to TWCC guidelines.

Patient Signature _____ Date _____

PRiME Diagnostic Imaging

PATIENT HISTORY & SCREENING FORM

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

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? _____

MRI patients only

	Yes	No
Cardiac 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?_____

Patient Signature _____ Date _____

PRiME Diagnostic Imaging

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 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 _____

Prime Diagnostic Witness _____ Date _____

PRiME Diagnostic Imaging

PREGNANCY STATUS INFORMATION

This form is for female patients only. Male patients may skip this page.

Patient Name: _____

Age: _____ Are you pregnant: Yes_____ No_____ Maybe_____

Are you pre or post menopause? ☐ Pre ☐ Post (If post menopause, you may skip the rest of this form.)

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(s) used:

☐ Birth control pills
☐ Husband vasectomy
☐ Abstinence/Inactive
☐ Other, please specify _____
☐ IUD
☐ Sponge

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

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

Are you breastfeeding? ☐ Yes ☐ No

I have read and understand the above information and give my authorization for all procedures ordered.

Patient Signature _____ Date _____

Prime Diagnostic Witness _____ Date _____

PRiME Diagnostic Imaging

LETTER OF PROTECTION/WORK COMP

Is your injury or condition the result of an accident? **If yes**, please thoroughly complete this page. **If not**, please move on to next page.

TYPE OF ACCIDENT

Check all that apply:

☐ Motor Vehicle Accident ☐ 18-wheeler Accident ☐ Slip and Fall ☐ Pedestrian

☐ On the Job ☐ DWI ☐ Other _____

ATTORNEY INFORMATION

Name of Attorney: _____ Attorney's Phone #: _____

Date of Injury: _____

PATIENT'S MOTOR VEHICLE INSURANCE

Carrier's Name: _____ Policy Number: _____

Name of Insured: _____

Coverage: PIP: _____ UM/UIM: _____ MEDPAY: _____

DEFENDANT'S MOTOR VEHICLE INSURANCE

Carrier's Name: _____

Name of Insured: _____

Policy Number: _____ Claim Number: _____

ACCIDENT INFORMATION:

Did the Defendant receive a ticket? ☐ Yes ☐ No Police Report filed? ☐ Yes ☐ No

City where the accident happened: _____

How did the accident happen: _____

_____

_____

Property Damage: ☐ $0-$500 ☐ $500-$1000 ☐ $1000-$5000 ☐ $5000 or more ☐ Totaled

PRiME Diagnostic Imaging

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, Cellular Medicine Solutions, 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 co-payment, 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 Signature _____ Date _____

Guardian (If patient is a minor) _____ Date _____

Prime Diagnostic Witness_____ Date _____

PRiME Diagnostic Imaging

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 Or Personal Representative

Date

Printed Name of Above Signature

Relation to Patient if Signed by Representative

Prime Diagnostic Witness

PRiME Diagnostic Imaging

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name: _____ 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 Images
☐ Clinical 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. 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 in one year, or:

_____ On the following date: _____

Patient Signature _____ Date _____