

Carlsbad Imaging Center
(760) 730-3536

PATIENT PERSONAL INFORMATION

Last Name: _____ First Name: _____ Middle: _____

Street Address: _____ Apt# _____

City: _____ State: _____ Zip Code: _____ Driver License (State & #) _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Date of Birth: _____ Sex: Female Male Social Security Number: _____

Marital Status: Single Married Divorced Widowed

Name of Employer or School: _____

Is your condition a result of work comp? Yes No If yes, please give date of injury _____

PATIENT'S PRIMARY INSURANCE INFORMATION

Primary insurance company's name _____

Name of Insured: _____ Date of Birth: _____

Relationship to Insured Self Spouse Child other _____

PATIENT'S SECONDARY INSURANCE INFORMATION

Secondary insurance company's name _____

Insurance Address: _____

Name of Insured: _____ Date of Birth: _____

Relationship to Insured Self Spouse Child other _____

AUTHORIZATION OF RELEASE OF MEDICAL RECORDS AND FILMS

I, _____, hereby authorize, the above named facility, to release the medical records, diagnostic report and /or film of:

Patient's Name: _____

Date of Birth: _____ Medical Record# _____

Specific exam/exams: _____ Date of service: _____

To: Name: _____ Phone: _____

I understand that this authorization shall become effective immediately and shall remain in effect until I revoke it, in writing. I also agree to pay any fee associated with copying of second set of films.
Applicable Fees: \$15.00 per film

Print Name: _____

Signature: _____ Date: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Street Address: _____ Apt# _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

AUTHORIZATION

† **ASSIGNMENT OF BENEFITS:** I hereby authorize and direct my insurance carrier to pay directly to this provider of medical services any benefits due me under my insurance plan. I also hereby authorize this provider to use and disclose any of my personal medical information for treatment/diagnosis and payment (including to my insurance company). I agree to pay the balance of charges not paid under my plan. I am aware that if my account is not paid in full within 90 days from the date of the service, a 30% additional fee will be added to the balance and it will be sent directly to a collection agency and reported to a national credit bureau. The returned checks will also be charged a \$25.00 fee. Should the account be referred to an attorney for collection, the undersigned shall pay attorney's fees and other collection expenses. **IF I AM UNINSURED, I am fully responsible for all charges.**

Signature: _____ Date: _____

† **CONSENT FOR MEDICAL TREATMENT/DIAGNOSIS:** I authorize the imaging Center to furnish the necessary medical treatment , or procedures, including diagnostic x-ray, local anesthesia, drugs, and supplies as may be ordered by the attending physician(s), his assistants or designees. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatment or diagnostic procedures conducted in the Imaging Center.

Signature: _____ Date: _____

† **LIFETIME MEDICARE B SIGNATURE AUTHORIZATION:** I authorize any holder of medical or other information about me to release to the Social Security Administration and center for Medicare & Medicaid Services or it's intermediaries or carriers, or to the billing agent of the Imaging Center any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical benefits be made to the holder of this assignment on my behalf. I understand that I am responsible for any deductible and coinsurance.

Signature: _____ Date: _____

IF PATIENT IS UNDER 18: I hereby give my permission for _____ to be treated at the Imaging Center.

In accordance with city, state, and federal laws and regulations, including the Health Insurance Portability and Accountability Act of 1996 (**HIPAA**), **Carlsbad Imaging Center** will protect patient records and other information that may reveal a patient's identity when using or disclosing such information for purposes of treatment, payment, or health care operations. I am aware that I can request to review the policy of **Carlsbad Imaging Center** for patient's privacy.

Signature: _____ Date: _____

MRI PATIENT HISTORY

Carlsbad Imaging Center
3144 El Camino Real Suite 100
Carlsbad, CA 92008
(760) 730-3536

Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: _____ Male Female

1) Body Part to be examined: _____

2) Reason for MRI and/or Symptoms: _____

3) How long have you been experiencing these symptoms? _____

4) Have you had a prior surgery on the body part being examined today? No Yes

If yes, please indicate the date and type of the surgery: _____

5) Have you had prior diagnostic imaging study of this body part (MRI, CT, Ultrasound, x-rays)? No Yes

If yes, please list the exam: _____ date: _____ facility: _____

exam: _____ date: _____ facility: _____

6) Do you have history of sickle cell disease? No Yes

7) Have you ever experienced allergic reaction to MRI contrast/Gadolinium? No Yes

8) For Female patients: Is there any chance you could be pregnant? No Yes

Are you currently breastfeeding? No Yes

Please indicate if you have any of the following:

- Yes No Aneurysm clip(s)
- Yes No Cardiac pacemaker
- Yes No Implanted device
- Yes No Neurostimulation system
- Yes No Cochlear, otologic, or other ear implant
- Yes No Heart valve prosthesis
- Yes No Artificial or prosthetic limb
- Yes No Metallic stent, filter, or coil
- Yes No Shunt (spinal or intraventricular)
- Yes No Medication patch (Nicotine, Nitroglycerine)
- Yes No Any metallic fragment or foreign body including within the eye
- Yes No Surgical staples, clips, or metallic sutures
- Yes No Joint replacement (hip, knee, ect.)
- Yes No IUD, diaphragm, or pessary
- Yes No Tattoo or permanent makeup
- Yes No Body piercing jewelry
- Yes No Hearing aid (*Remove before entering MR system room*)

WARNING: Before entering the MR environment or MR system room, you must remove all metallic objects including hearing aids, dentures, partial plates, keys, beeper, cell phone, eyeglasses, hair pins, barrettes, jewelry, body piercing jewelry, watch, safety pins, paperclips, money clip, credit card, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clipper, tools, clothing with metal fasteners, & clothing with metallic threads.

Certain implants, devices, or objects may be hazardous to you and /or may interfere with the MR procedure. Do not enter the MR system room or MR environment if you have any questions or concern regarding an implant, device, or object. Consult the MRI Technologist or Radiologist BEFORE entering the MR system room. The MR system magnet is ALWAYS on.

I attest that the above information is correct to the best of my knowledge. I read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form and regarding the MR procedure that I am about to undergo.

Signature of the person completed form: _____ Date: _____

Form Completed By: Patient Spouse relative Interpreter Nurse Relationship to patient: _____