MRN # _____

PATIENT REGISTRATION

Last Name_____ **First** Name_____ Middle_____

Mailing Address / PO BOX / APT# / UNIT#_____

City _____ State _____ Zip _____

Date of Birth _____ ☐ Female ☐ Male Social Security # _____

CELL Phone _____ **HOME Phone** _____

Employer or School _____ **WORK Phone** _____

Driver's License(State & #)_____ Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Email Address _____

EMERGENCY Contact Name / Phone # / Relationship _____

PLEASE ANSWER / CIRCLE LINES 1 - 5

1. Today's exam date _____

2. Is today's exam related to a WORK INJURY? (Work Comp) **YES** **NO**

3. Is today's exam related to a PERSONAL INJURY CASE? **YES** **NO**

4. Is today's exam related to a: **Motor Vehicle Accident** **YES** **NO**

Slip and Fall **YES** **NO**

5. Date of Injury _____ **State where accident / injury occurred** _____

Other / Notes_____

→ **PRIMARY Insurance Company** _____

Primary policy holder _____ His/Her Date of Birth _____

Relationship to primary policy holder ☐ Self ☐ Spouse ☐ Child ☐ Other _____

→**SECONDARY Insurance Company** _____

Secondary policy holder _____ His/Her Date of Birth _____

Relationship to secondary policy holder ☐ Self ☐ Spouse ☐ Child ☐ Other_____

PLEASE TURN THIS PAGE OVER →

MRN # _____

AUTHORIZATIONS

AUTHORIZATION OF RELEASE OF MEDICAL RECORDS AND CD / FILMS: I hereby authorize Carlsbad Imaging Center / Imperial Radiology to release my medical records, diagnostic reports, or CD/images to my referring physician(s). 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 the fee of $15 associated with copying of a second CD of images.

ASSIGNMENTS OF BENEFITS: I authorize and direct my insurance carrier to pay directly to this provider of medical services any benefits due to me under my insurance plan. I also hereby authorize this provider to use and disclose any of my personal medical information for treatments / diagnosis and payment (including to my insurance company). I agree to pay the balance of charges not paid under my plan. I understand that a $5 late fee will be added to each additional statement generated for the balance that remains unpaid after 30 days from the initial statement date. I am aware that if my account is not paid in full 90 days from the date of the service **a 30% additional fee will be added to the balance, it will be sent directly to a collection agency and reported to a national credit bureau.** Returned checks will also be charged a $25 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.

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/her assistances 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 procedure conducted in the Imaging Center.

LIFETIME MEDICARE PART B AUTHORIZATION: If I have a Medicare Part B policy, I authorize any holder of medical or other information about me to be released to the Social Security Administration and Centers for Medicare & Medicaid Services or its intermediaries or carries, or to the billing agent of the Imaging Center any information needed for this or 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 assignments on my behalf. I understand that I am responsible for any deductibles and coinsurances.

HIPAA: In accordance with city, state, and federal laws and regulations, including the Health Insurance Portability and Accountability Act of 1996 **(HIPAA), Carlsbad Imaging Center / Imperial Radiology** 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, and health care operations. I am aware that I can request to review the policy of **Carlsbad Imaging Center / Imperial Radiology** for patient's privacy.

IF THE PATIENT IS UNDER 18: I , _____
(Printed Name of Parent / Legal Guardian)

am the parent / legal guardian of _____
(Printed Name of Patient under 18)

I have read and understand the above written material in regards to the exam(s) for today's date of service.

Patient / Legal Guardian PRINTED name _____

Patient / Legal Guardian Signature _____ Date _____

NOTIFICATION REGARDING FINANCIAL RESPONSIBILITY FOR MEDICAL SERVICES

1. I understand and acknowledge that my Insurers will only pay for services that they determine to meet their coverage requirements and benefit terms.

2. As examples: some insurers require prior authorization for certain services. Some insurers have decision-makers that disagree with the medical necessity of certain recommended treatments, tests or examinations.

3. If my Insurer determines that the services or any part of them are not medically necessary, or fail to meet other coverage requirements (such as obtaining authorization or filing a claim in a limited time), the Insurer may deny payment for that service.

4. I agree that if my Insurer denies all or any part of the Provider's charges for any reason, or if I'm not eligible at the time of service, I will be personally and fully responsible for payment of Provider's charges. Should my account be referred to an attorney or collection agency, I agree to pay actual attorney fees and collection expenses. All delinquent accounts shall bear interest at twelve percent per annum, not to exceed the maximum amount permitted by law.

5. Deductions and Copays cannot always be predicted at the time of service, as patients' benefits can change throughout the year. It is the responsibility of the patient/payee to communicate directly with their insurance carrier to determine the final cost of the service.

6. The undersigned certifies that he/she has read and understands the information above, and is the patient, or the person financially responsible for the patient's treatment needs, and is duly authorized to sign this document.

Name: _____ Date: _____

Signature: _____

NAME: _____ DOB: _____

CT QUESTIONNAIRE

This x –ray examination of the body is done by using a special computer which allows us to view internal organs which we are not able to visualize using standard x-ray.

1. In one sentence, please describe what the problem is that brought you to our office today, include any symptoms you experience: _____

2. If you had any other test related to this problem, please list the test and the facility where the test was performed:

_____

3. Please list any surgeries you have had:

_____

4. Have you ever been told you had cancer? □ YES □ NO If yes, what body part was affected?

_____

5. Is there any chance you could be pregnant? □ YES □ NO

6. Are you currently breastfeeding? □ YES □ NO _____

CT INFORMED CONSENT FOR CONTRAST

Some CT examinations require the injection of a contrast media into your bloodstream. The use of this solution helps us to better visualize certain organs inside the body for diagnosis purpose. The contrast agent is given through a small needle placed into the vein. Contrast media is considered quite safe; however, any injection carries a risk of harm including injury to a nerve, artery or vein, or infection or reaction to the material being injected. Occasionally, a patient will have a mild reaction to the contrast material and develop sneezing and/or hives. Uncommonly, more serious reactions have been known to occur, including life-threatening reactions. These serious reactions are very rare. If you have any question, please feel free to discuss them with the Technologist or Radiologist prior to your scan.

1. Have you ever had an "allergic" like reaction to any contrast material? □ YES □ NO
2. Do you have allergies or asthma? □ YES □ NO
3. Do you have high blood pressure? □ YES □ NO
4. Do you have myeloma, sickle cell disease, polycythemia, or pheochromocytoma? □ YES □ NO
5. Do you have a history of kidney disease or diabetes? □ YES □ NO
6. Do you take Glucophage (Metformin)? □ YES □ NO

THE UNDERSTANDING CERTIFIES THAT HE/ SHE HAS READ AND UNDERSTANDS THE FOREGOING, AND IS THE PATIENT OR IS DULY AUTHORIZED BY THE PATIENT AS THEIR AGENT TO GIVE THE CONSENT TO HAVE THE DESCRIBED PROCEDURE PERFORMED.

Patient signature/Patient guardian: _____ Date: _____