Riverside Imaging Specialists
Registration and Medical Information Release

FIRST NAME (Please Print)	MIDDLE INITIAL	LAST NAME

STREET ADDRESS **CITY/STATE/ZIP**

CONTACT NUMBER: primary ( ) _____ secondary ( ) _____

SS# **BIRTHDATE** **GENDER (M / F)**

RELATIONSHIP TO SUBSCRIBER: _____SELF _____SPOUSE _____CHILD _____OTHER

MARITAL STATUS: _____SINGLE _____MARRIED _____DIVORCED _____WIDOWED

INFORMATION FOR SELF

Employer:	**Spouse:**
Employer Address:	**Spouse DOB:**
City/State/Zip:	**Spouse Employer:**
Phone Number:	**Employer Address:**
	City/State/Zip:
	Phone Number:

GUARANTOR INFORMATION

Last Name	**First Name**	**Middle Initial**
Mailing Address	**City/State/Zip**	
Phone Number:	**Relationship to Patient**	
Social Security Number	**Date of Birth**	

Please Initial Below

_____I request that this facility render medical services to me.

_____I understand that I am fully responsible for payment of all charges resulting from such authorized medical treatment, and that such charges are due and payable at the time of service unless I have made other arrangements regarding a fee payment schedule.

_____I authorize this facility to release information regarding my MRI/CT and or my medical condition and treatment to my insurance company, physician, attorney and/or other healthcare professionals involved in my medical care. I hereby release this facility from all legal responsibility or liability that may arise from the act I have authorized.

_____ I hereby authorize this facility to obtain any medical records and/or reports from my physician, hospital or other facility. This information is to be used for comparison, as well as my diagnosis.

_____I authorize payment of benefits from my insurance coverage directly to this facility.

Signature:_____ Date:_____

Patient ID Number: _____

MRI PATIENT SCREENING FORM

Name: _____ Date:_____

Date of Birth: _____Age:_____Sex:_____Weight:_____Height:_____

PLEASE ANSWER THE FOLLOWING QUESTIONS:

What complaint/symptom led you to see the doctor? _____

How long have you had your symptoms? _____

Have you had a prior diagnostic imaging study of the body part we are scanning today? YES NO
(MRI, CT, Ultrasound, X-Ray, etc) If yes, please list:

_____

Do you have a history of asthma, allergic reaction, respiratory disease, or reaction to a contrast medium or dye used for an MRI, CT, or X-ray examination? YES NO

Please indicate any allergies: _____

Do you have Diabetes? YES NO

Do you have a history of kidney disease? YES NO
If YES, are you on dialysis? YES NO Next scheduled dialysis: _____

Do you have a personal history of Cancer? YES NO Type & Date diagnosed: _____
Do you have sickle cell anemia? YES
NO

Are you pregnant or breastfeeding? YES
NO

YES
Are you claustrophobic? NO

If YES, are you taking any medication to help you get through the exam? YES NO
(eg. Xanax, Valium, etc.) *Please notify office staff immediately if you are taking these medications.

Any injury to your eyes or body involving a metallic object or fragment? YES NO
(eg. Metallic slivers, shavings, foreign body, bullets, BB, shrapnel, etc.)

Please list all previous surgeries and dates, specifically the surgeries to the body part we are scanning today.

_____

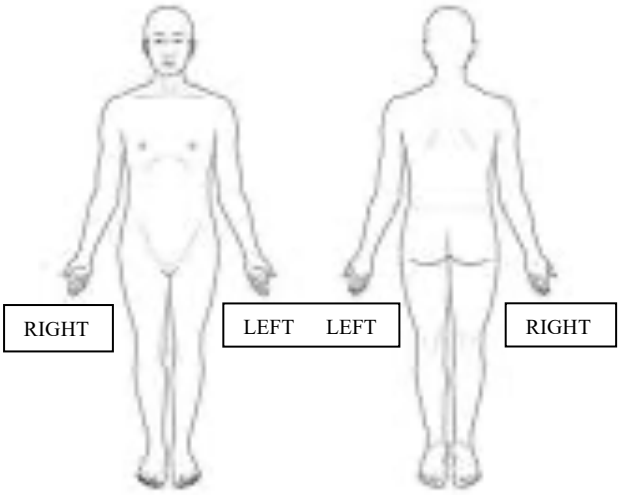
_____

WARNING: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure (i.e., MRI, MR angiography, functional IMRI, MR spectroscopy). Do not enter the MR system room or MR environment if you have any question 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.

Please indicate if you have any of the following:

❒Yes ❒ No Aneurysm clip(s)
❒Yes ❒ No Cardiac pacemaker
❒Yes ❒ No Implanted cardioverter defibrillator (ICD)
❒Yes ❒ No Electronic implant or device
❒Yes ❒ No Magnetically-activated implant or device
❒Yes ❒ No Neurostimulation system
❒Yes ❒ No Spinal cord stimulator
❒Yes ❒ No Internal electrodes or wires
❒Yes ❒ No Bone growth/bone fusion stimulator
❒Yes ❒ No Cochlear, otologic, or other ear implant
❒Yes ❒ No Insulin or other infusion pump
❒Yes ❒ No Implanted drug infusion device
❒Yes ❒ No Any type of prosthesis (eye, penile, etc.)
❒Yes ❒ No Heart valve prosthesis
❒Yes ❒ No Eyelid spring or wire
❒Yes ❒ No Artificial or prosthetic limb
❒Yes ❒ No Metallic stent, filter, or coil
❒Yes ❒ No Shunt (spinal or intraventricular)
❒Yes ❒ No Vascular access port and/or catheter
❒Yes ❒ No Radiation seeds or implants
❒Yes ❒ No Swan-Ganz or thermodilution catheter
❒Yes ❒ No Medication patch (Nicotine, Nitroglycerine)
❒Yes ❒ No Any metallic fragment or foreign body
❒Yes ❒ No Wire mesh implant
❒Yes ❒ No Tissue expander (e.g., breast)
❒Yes ❒ No Surgical staples, clips, or metallic sutures
❒Yes ❒ No Joint replacement (hip, knee, etc.)
❒Yes ❒ No Bone/joint pin, screw, nail, wire, plate, etc.
❒Yes ❒ No IUD, diaphragm, or pessary
❒Yes ❒ No Dentures or partial plates
❒Yes ❒ No Tattoo or permanent makeup
❒Yes ❒ No Body piercing jewelry
❒Yes ❒ No Hearing aid (Remove before test)
❒Yes ❒ No Other implant _____
❒Yes ❒ No Breathing problem or motion disorder
❒Yes ❒ No Claustrophobia

Please mark on the figure(s) below the location of any implant or metal inside of or on your body.



IMPORTANT INSTRUCTIONS

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

Please consult the MRI Technologist or Radiologist if you have any questions or concern **BEFORE** you enter the MR system room.

NOTE: You may be advised or required to wear earplugs or other hearing protection during the MR procedure to prevent possible problems or hazards related to acoustic noise.

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 Person Completing Form:_____ Date_____/_____/_____
Signature

Form Completed By: ❒ Patient ❒ Relative ❒ Nurse _____ _____
Print name Relationship to patient

Form Information Reviewed By: _____ _____ ❒ MRI Tech ❒ Other _____
Print name Signature

AUTHORIZATION TO RELEASE
MEDICAL INFORMATION
TO INDIVIDUALS/FAMILY MEMBERS

Patient Name: _____

I the named patient above fully authorize Riverside Imaging Specialists, to disclose and use my protected health information related to my imaging procedure, to any healthcare provider treating me or involved in my current diagnosis or treatment.

Additionally, any one or all the following individuals listed below may have complete access to my health information, medical records and account records:

_____

Name **Relationship to Patient**

_____

Name **Relationship to Patient**

_____

Name **Relationship to Patient**

RECEIPT AND ACKNOWLEDGEMENT OF PRIVACY PRACTICES

_____ *By check mark*, I agree and acknowledge that I have reviewed a copy of a Notice of Privacy Practices concerning Protected Health Information.

_____ *If marked by X*, I acknowledge receipt of this Notice of Privacy Practices, but choose not to read this information regarding my Protected Health Information.

_____ _____

Signature of Patient or Patient's Legal Representative (if applicable) **Date**

RIVERSIDE IMAGING SPECIALISTS, LLC

YOUR HEALTH INFORMATION AND PRIVACY

WE RESPECT AND SAFEGUARD YOUR PRIVACY AND HEALTH INFORMATION

- Federal Law protects and outlines who may see and receive your protected health information (PHI).

- Providers, facilities, employer group plans, Medicare, Medicaid and other insurance companies all must follow the laws regarding PHI.

- Information, conversations, billing information, and information kept and contained in computers systems is all protected under the law.

- Your rights over the use and confidentiality of your PHI provide that, you may get copies of your health records, request corrections to your PHI, receive notice as to how your information may be used, decide if you will allow your information may be used or shared for other purposes such as marketing, get reports on when and why your PHI was shared and with whom.

- If you believe your rights have been denied or isn't being protected your may file a complaint with your provider, health care insurer, or the U.S. government. To do so you may go online to the website below:
  www.hhs.gov/ocr/hippa/ or call 1-866-627-7748 toll free.

YOUR INFORMATION MAY BE USED FOR:

- Your treatment and care and the coordination of same.
- To pay hospitals, clinics, doctors, imaging facilities and other providers of care to help in running their businesses.
- To protect the health of the general public in the case of communicable diseases.
- To make sure doctors and other providers give proper care and that police receive vital information about such incidents such as gunshot wounds or similar physical trauma.
- To share PHI including health care bills with designated immediate family members or other relatives, friends, or others you identify that may be involved in your health care, unless you object.

WE MAY NOT USE YOUR PHI UNLESS YOU GIVE WRITTEN PERMISSION UNLESS THE LAW ALLOWS. WITHOUT YOU AUTHORIZATION WE CANNOT SHARE YOUR PHI WITH YOUR EMPLOYER, OR FOR ANY PURPOSE SUCH AS MARKETING OR ADVERTISING.
WE MAY NOT SHARE ANY MENTAL HEALTH OR COUNSELING INFORMATION.

THE LAW ALSO PROTECTS YOUR HEALTH INFORMATION BY REQUIRING HEALTH CARE PROVIDERS AND INSURERS TO TEACH PEOPLE HOW YOUR PHI MAY BE USED AND TO KEEP IT SECURE.

YOU MAY OBTAIN MOR INFORMATION BY CONTACTING THE MANAGER AT 478-745-6747 OR EMAILING: THE MANAGER at the web address jessica@riverside-imaging.com.