ENVISION IMAGING REGISTRATION INFORMATION

PATIENT INFORMATION (PLEASE USE FULL LEGAL NAME)

Last:_____ First:_____MI:_____Sex: _____

DOB:_____ SSN# _____ Marital Status:_____ Home Phone: _____

Address: _____ Cell Phone: _____

City:_____State:_____ Zip:_____

Email:_____Employer:_____Work Phone: _____

Emergency Contact Name:_____Emergency Contact Phone #: _____

RESPONSIBLE PARTY INFORMATION

Name:_____Relationship:_____Phone:_____

Address:_____ DOB_____SSN#:_____

Employer: _____Work Phone #_____

INSURANCE INFORMATION

On the job injury: Yes / No Motor Vehicle Accident: Yes / No Injury Date: _____

Primary Insurance

Insurance Company:_____Policy #:_____Group Number: _____

Policy Holder Name: _____Policy Holder DOB: _____

Adjuster Name / Phone #: _____

Secondary Insurance

Insurance Company:_____Policy #:_____Group Number: _____

Policy Holder Name: _____Policy Holder DOB: _____

RELEASE OF INFORMATION AND PAYMENT AUTHORIZATION

I authorize the release of information necessary to process this claim and assign benefits payable for services directly to Envision Imaging. I authorize the release of any medical information necessary for treatment by my current or future physician or healthcare provider.

I authorize Envision Imaging to release to my insurance company any medical information which may be necessary to process my insurance claim. I understand that in the event my insurance company denies this claim I may be held financially responsible for all charges.

I acknowledge that I have read and had the opportunity to receive a copy of Envision Imaging's Privacy Notice.

Printed Name: _____

Signature: _____ Date: _____

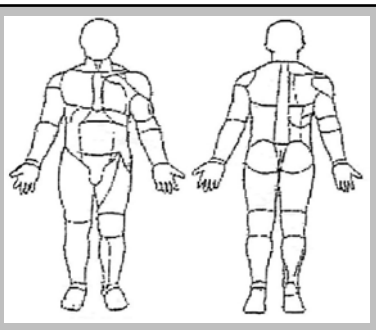
ENVISION IMAGING

Patient MRI/CT History Form

Patient Name: _____ Date of Birth:_____

Do you have any of the following items in your body?			
Pacemaker / Defibrillator /Pacer Wires	YES	NO	
Ear Surgery/Cochlear Implant/Hearing Aids	YES	NO	
Brain Aneurysm Clips or Coils	YES	NO	
Any metal / foreign body removed from eyes	YES	NO	
Gun Shot Wound, Shrapnel, or Metal Fragments in body	YES	NO	
Implanted electrical devices Pain Pump/Insulin Pump	YES	NO	
Any other Implants	YES	NO	
Tattoos/Permanent Make-up/Body Piercings	YES	NO	
Colonoscopy/Endoscopy/Gastric Scope	YES	NO	If Yes, Date performed:_____
If YES, were clips placed in the GI Tract	YES	NO	If Yes, Date performed:_____
Brain Shunt	YES	NO	
Neurostimulators	YES	NO	
Stents in Heart /Legs / Kidneys /Other	YES	NO	
Dentures held in with magnets	YES	NO	
Any Transdermal Patches (medication patches)	YES	NO	(If Yes, needs to be removed prior to MRI)

Do you have any History of the following?		
History of Myeloma / Multiple Myeloma?	YES	NO
Liver transplant or failure?	YES	NO
Are you Diabetic (type I or II)?	YES	NO
Asthma?	YES	NO
History of KIDNEY FAILURE, Kidney surgery, or Kidney Cancer?	YES	NO
Are you currently on dialysis / blood transfusion?	YES	NO
Do you take any medication for hypertension (high blood pressure)?	YES	NO
Heart Failure / Heart Surgery	YES	NO
Are you on any blood thinners?	YES	NO
Are you taking any of the following: (*If yes, Circle Medication below*) Glucophage, Glucovance, Metformin, Actos Plus Met, Avandamet, Fortamet, Metaglip, Glumetza, Riomet, or Janumet?	YES	NO
FOR SPINE EXAMS: Any Leg or Arm Pain?	YES	NO



Please Mark Area of Pain

FEMALE PATIENTS ONLY:				
Any possibility of being pregnant?	YES	NO	Patient Initials_____	Tech Initials_____
Are you breast feeding?	YES	NO	Patient Initials_____	Tech Initials_____

Have you ever had an Injection of Contrast? YES NO

If Yes, Did you experience an allergic reaction to Contrast (***Please Explain***) _____

List drug allergies: _____

List of other Medications that you are currently taking: _____

Current Weight: _____

Please list previous surgeries: _____

Signature of Patient/guardian:_____ Date___/___/_____

Technologist/Witness Signature: _____ Date:___/___/_____

ENVISION IMAGING

INFORMED CONSENT FOR CT SCAN
WITHOR WITHOUT CONTRAST INJECTION

PATIENT NAME:_____

IF YOU ARE PREGNANT OR THINK THAT YOU MAY BE PREGNANT, PLEASE INFORM THE FACILITY PERSONNEL AT ONCE.

Your physician has requested that we perform a computerized tomography scan (CT) to obtain additional information. This is a diagnostic test that uses x-ray and a computer to produce images of internal body parts.

As part of your examination, we may need to inject you with a contrast solution containing iodine. This clear, colorless liquid is removed from your body by your kidneys and will not alter the appearance of your urine. It will show up on the images to provide important diagnostic information.

Soon after the injection you may experience a metallic taste and a warm sensation. You may feel some nausea. These feelings last only a short time.

Occasionally, minor allergic reactions occur in the form of itching, sneezing, hives, swelling of the eyes or wheezing. These symptoms may require treatment with medication we have on hand. It is very important that you inform the technologist if you experience any of the conditions mentioned in this form.

Rarely, a more serious reaction will occur. Even though it is extremely rare, medical statistics indicate that a fatality may occur from the injection of contrast. If you have had a reaction to a contrast injection previously or a history of asthma or other allergic conditions, any history of diabetes or any kidney disorder, anemia or sickle cell anemia, if you are taking Glucophage, are pregnant or breast feeding, you MUST inform the technologist.

The benefit of this exam is to assist your physician with making a diagnosis. There may be other imaging alternatives, however, your physician believes the CT scan to be the best diagnostic test for you after evaluating your symptoms and medical condition.

By my signature below, I hereby certify that I have fully read this consent, had it explained to me or have had it read to me. I have been given an opportunity to ask questions about my condition, alternative forms of treatment, the procedures to be used, and the risks and hazards involved. I understand its contents and have sufficient information to give this informed consent.

_____DATE: _____
Patient/Parent/Legal Guardian Signature

_____DATE:_____
Technologist Signature

ENVISION IMAGING

Patient Authorization

Section I : Receipt Acknowledgement for the Notice of Privacy Practices

I,_____have been made aware of the notice of Privacy Practices for Envision Radiology, dba as Envision Imaging, Health Images and Colorado Springs Imaging and further referred to as "Envision Radiology." I understand that this notice states how Envision Radiology may use and disclose my Protected Health Information ("PHI.")

I UNDERSTAND THAT A COPY OF THIS NOTICE IS AVAILABLE UPON REQUEST.

_____*Initial*

Section II: Consent for Treatment

I authorize Envision Radiology, to perform all exams, tests, procedures, injections and any other care deemed necessary or advisable for the diagnosis and treatment of my medical condition(s.)

_____*Initial*

Section III: Consent for Release & Acquisition of Medical Records

In order to provide the most accurate reading of my current studies and to assure that I am receiving the highest quality of care, I consent to Envision Radiology obtaining any of my previous images, radiology reports, pathology reports, or results of surgical intervention for comparison to my current studies and to track abnormal results. For the same purpose, Envision Radiology may release my studies performed at an Envision Radiology facility to my treating physicians and medical facilities, upon their request.

In order for Envision Radiology to obtain and release my records in a timely manner, I authorize Envision Radiology to convey my records and images by Certified Mail, Courier or Electronic Transmission.

Initial

Section IV: Release of Records to a Designated Third-Party

In addition to my treating physicians and medical facilities, I authorize Envision Radiology to release my records and images to the following individuals. (This should include **friends or family members** responsible for picking up your records when you are unable to do so.) PLEASE PRINT

Name: _____ Phone: _____

Name: _____ Phone: _____

_____*Initial*

Patient Signature:

By signing below I am verifying that I have read each of the four sections on this page. I understand each section and consent to and agree with the information stated in each section.

_____ _____

Patient / Legal Representative Signature **Date**

_____ _____

Patient's Printed Name **Date**

ENVISION IMAGING

Preliminary Ebola Virus Disease Screening

Patient Name: _____ Date of Birth:_____

For the safety of our patients and staff, please answer the following questions:

1. Do you have a fever equal to or greater than 101.5 degrees Fahrenheit? **Yes / No**

2. Are you complaining of EVD-compatible symptoms, such as headache, weakness, muscle pain, vomiting, diarrhea abdominal pain or hemorrhage? **Yes / No**

If you answer NO to these questions, Stop and sign below.

_____ _____

Patient/Parent/Legal Guardian Signature ***Date***

If you answer YES to any of the above questions, please review and answer the questions below:

1. Have you traveled to an Ebola-affected country in the 21 days before the onset of illness? (Currently Liberia, Sierra Leone, and Guinea). **Yes / No**

2. Have you been in contact with a sick individual who has recently traveled to one of the Ebola affected countries or a person known or suspected of having Ebola? **Yes / No**

If you answer NO to these questions, please sign below:

_____ _____

Patient/Parent/Legal Guardian Signature ***Date***

If you answer YES to question 3 or 4, please immediately notify the center manager or radiologist.