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: _____

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Patient MRI/CT Screening/Safety Form

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*)	YES	NO
Glucophage, Glucovance, Metformin, Actos Plus Met, Avandamet, Fortamet, Metaglip, Glumetza, Riomet, or Janumet?		

ALLERGIES

Have you ever had an Injection of Contrast? Yes / No *If YES, did you experience an allergic reaction to Contrast? (Please Explain)*_____

Drug Allergies: _____

Are you currently breastfeeding? Yes / No

Current Weight: _____ Current Height: _____

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

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

ENVISION IMAGING

Clinical History/Screening Form

Current Symptoms/Patient History (Please describe detailed symptoms related to today's exam including time frame): _____

_____

_____

_____

_____

_____

FOR SPINE EXAMS: Any Leg or Arm Pain? YES / NO

Surgeries: _____

Prior treatments for this problem: Yes / No **If so, what treatment?** _____

Prior Exams Related to this problem: _____**Location:**_____

Cancer History: _____

Diagnosed: ___/___/____ Chemo Therapy: Yes / No Radiation Therapy: Yes / No

Other Medical Problems *(underlying Conditions):*_____

_____

List of Medications: _____

FEMALE PATIENTS: **Any possibility of pregnancy?** Yes / No / NA **Patient Initials**: _____ **Tech Initials:** _____

Patient Signature: _____**Date:** ____/ _____/ ____

FOR OFFICE USE ONLY

Technologist Notes:_____

_____

_____

_____

Pertinent Surgical HX:_____

Encounter Type: Initial / Subsequent / Sequela **Acute / Chronic** *Timeframe:* _____

Other Details: **Traumatic/** Non-**traumatic** **DOI -** _____ **Fractures:** Closed / Open

Anatomical Site: _____ **Location**: R / L / B **Quadrant** _____ / N/A

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

CONTRAST INFORMATION ____ ***Not Applicable to this exam***

Amount	*Type of Contrast*	*Puncture site*	*Lot #*	*Expiration Date*
_____cc of	_____	_____	_____	_____

CONTRAST REACTION: YES / NO Tech Initials: _____ SUPERVISING RAD: _____

If yes attach Clinical Incident and adverse reaction report and forward to Safety Officer

ENVISION IMAGING OF TULSA

INFORMED CONSENT FOR ARTHROGRAM

PATIENT NAME: _____ **DATE:** _____

You have the right to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to alarm you, but rather to inform you of your procedure so that you may choose to give or withhold your consent for the procedure.

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 an arthrographic examination of your_____. The purpose of this procedure is to provide information to aid your physician in diagnosing and treating your complaint.
This procedure involves administering a local anesthetic and injecting a contrast medium in the_____ joint through a needle. There may be a slight burning sensation when the anesthetic agent in injected. This will pass quickly. During injection of the contrast medium, you may feel pressure or pain; this is normal for this procedure. Following this procedure, an MRI or CT exam may be performed to further evaluate the joint.

Potential Risks: The following complications are possible: anytime an injection is given, there is the potential for pain, bleeding, bruising or swelling at the injection site. Untreated complications could lead to loss of use of the joint. You can expect pain or soreness lasting up to 24 hours after the injection. Additional allergic reactions in response to the contrast agent may include hives, shortness of breath or difficulty 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 above.

If you have previously had a reaction to a contrast injection such as hives, severe itching, shortness of breath and/or any significant reaction requiring hospitalization, a history of asthma or other allergic conditions, any history of anemia, sickle cell anemia or kidney disorder, are **PREGNANT OR BREAST FEEDING** you **MUST** inform the technologist.

I CERTIFY THAT THIS FORM HAS BEEN FULLY EXPLAINED TO ME, THAT I HAVE READ IT OR HAVE HAD IT READ TO ME, AND THAT I UNDERSTAND ITS CONTENTS.

I HAVE BEEN GIVEN THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE ANESTHESIA, THE PROCEDURES TO BE USED, AND THE RISKS AND HAZARDS INVOLVED, AND I BELIEVE THAT I HAVE SUFFICIENT INFORMATION TO GIVE THIS INFORMED CONSENT.

_____
Patient/Parent/Legal Guardian Signature

_____
Technologist Signature

_____
Physician Signature

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**