CONQUEST IMAGING INC

9450 W COLONIAL DR OCOEE, FL 34761 P: 321-274-4414 F: 321-321-247-5557

PATIENT INTAKE INFORMATION

SECTION 1

First Name: _____ Middle Initial _____ Last Name_____

Sex: M___F___

Date of Birth: _____ Social Security #_____ Weight _____Height_____

Address: _____ City_____ State_____

Zip code_____

Phone Number #: _____ Can we leave a message at this number? Yes/No

Primary Insurance _____ Member ID#_____ Are you the primary card Holder? Y___ N___

If Yes Primary Card Holder Name _____ Phone _____

Referring Physician: _____Phone: _____ Fax: _____

Motor Vehicle Accident Y_____ N_____ Date of Accident _____

Auto Insurance _____ Are you the primary insured? Yes/no

If not, Name of Insured: _____

Claim # _____ Policy # _____

Attorney Name: _____ Case Manager: _____

Phone Number: _____ Fax: _____

SECTION 2

PREGNANCY STATEMENT **(Females Only)**

Are you pregnant / nursing or do you suspect that you could be pregnant? * Yes____ No_____

If 'YES', date of your last menstrual period? _____

Patient/Guardian Signature _____ Date: _____

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MRI SAFETY SCREENING QUESTIONNAIRE

The following items may be harmful to you during your MR scan or may interfere with the MR examination. Please provide a "yes" or "no" answer for every item.

Y N Cardiac pacemaker or implanted cardioverter defibrillator/ICD
Y N Internal electrodes or wires (pacing wires, DBS or VNS wires)
Y N Artificial heart value, coil, filter and/or stent (Gianturco coil, IVC filter)
Y N Aneurysm clip(s)
Y N Neurostimulator-TENS Unit, Biostimulator, bone growth stimulator, DBS, VNS
Y N Implanted drug pump (for chemotherapy medicine, pain medicine)
Y N External drug pump (for Insulin or other medicine)
Y N IV access port (Port-a-Cath, Broviac, PICC line, Swan-Gantz, Thermodilution)
Y N Implanted post-surgical hardware (pins, rods, screws, plates, wires)
Y N Artificial joint and /or limb
Y N Artificial eye and/or eyelid spring
Y N Eye injury from a metal object (metal shavings, metal slivers)
Y N Ear (Cochlear) implant, middle ear implant
Y N Hearing aid(s)
Y N False teeth/dentures, metallic removable dental work, braces, retainers
Y N Any type of implant held in place by a magnet
Y N Injured by a metal object (shrapnel, bullet, BB) and required medical attention
Y N Medication patch (nitroglycerine, nicotine, contraceptive, estrogen)
Y N Shunt or Sophy adjustable and programmable pressure valve
Y N Spinal fixation device, spinal fusion and/or halo vest, spinal cord stimulator
Y N Surgical clips, staples or surgical mesh
Y N Tissue expander (breast)
Y N Penile implant
Y N Pessary, IUD, Diaphragm
Y N Radiation seeds (cancer treatment)
Y N Body piercing, tattoo or permanent makeup
Y N Wig, hair implants

Other: _____
_____

Patient/Guardian Signature _____ Date: _____

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PLEASE REMOVE ALL PERSONAL ITEMS

Remove all items such as Jewelry, Hairpins, Wigs, Metallic Objects, Hearing Aids, Dentures and Credit Cards.

Leave all valuables with a responsible person accompanied by you or store all items in a locker that is provided to you for your convenience.

By signing below, I certify that I do not have any of the above listed items and I grant consent for the study.

I attest that the answers I have provided to the questions on this form are correct to the best of my knowledge. I have read and understand the entire contents of this form and have had the opportunity to ask questions regarding the information in this form.

Patient/ Legal Guardian Signature _____ Date_____

MRI Tech Name: _____

MRI Technologist Signature: _____

Date_____

Acknowledgement of CD receipt

I acknowledge receiving a CD of image for DOS: _____

The CD contains images of my _____ scan(s).

This CD is to be submitted to your referring physician immediately.

Should you lose or damage your CD, a replacement may be requested for a small administrative fee.

Patient signature: _____ Date: _____

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PATIENT'S BILL OF RIGHTS

Florida law requires that your health care provider or health care facility recognize your rights while you are receiving medical care and that you respect the health care provider's or health care facility's right to expect certain behavior on the part of patients. You may request a copy of the full text of this law from your health care provider or health care facility. A summary of your rights and responsibilities follows:

- A patient has the right to know who is providing medical services and who is responsible for his or her care.
- A patient has the right to know what patient support services are available, including whether an interpreter is available if he or she does not speak English.
- A patient has the right to be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.
- A patient has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.
- A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate.
- A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
- A patient has the right to receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.
- A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment.
- A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
- A patient has the right to express grievances regarding any violation of his or her rights, as stated in Florida law, through the grievance procedure of the health care provider or health care facility which served him or her and to the appropriate state licensing agency.
- A patient is responsible for providing to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health.
- A patient is responsible for reporting unexpected changes in his or her condition to the health care provider.
- A patient is responsible for reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.
- A patient is responsible for following the treatment plan recommended by the health care provider.
- A patient is responsible for keeping appointments and, when he or she is unable to do so for any reason, for notifying the health care provider or health care facility.
- A patient is responsible for his or her actions if he or she refuses treatment or does not follow the health care provider's instructions.
- A patient is responsible for assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.
- A patient is responsible for following health care facility rules and regulations affecting patient care and conduct.
- Inform his/her provider about any living will, medical power of attorney or other directive that could affect his/her care.
- Be respectful of all the health care providers and staff, as well as other patients.

I acknowledge that I have read and received a copy of the Patient's Bill of Rights and Responsibilities.

Patient signature: _____ Date: _____

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CONSENT TO USE OR DISCLOSE INFORMATION FORM

TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS & HIPAA NOTICE OF PRIVACY PRACTICES

PATIENT ACKNOWLEDGES AND AGREES THAT THE PRACTICE MAY DISCLOSE PATIENT'S PROTECTED HEALTH INFORMATION AND PATIENT MEDICAL RECORD INFORMATION TO THE FOLLOWING INDIVIDUALS WHO ARE EITHER THE PATIENT'S FAMILY MEMBERS, LEGAL REPRESENTATIVES, GUARDIANS, HEALTH CARE SURROGATES, OR HAVE POWER OF ATTORNEY ON BEHALF OF THE PATIENT:

WITH THIS CONSENT, MY PROVIDER AT **COR IMAGING CENTER INC.** MAY DISCUSS MY MEDICAL INFORMATION WITH:

NAME: _____ RELATIONSHIP_____PHONE #_____

NAME: _____ RELATIONSHIP_____PHONE #_____

NAME: _____ RELATIONSHIP_____PHONE #_____

THE PATIENT AGREES THAT THE PRACTICE MAY DISCLOSE THE FOLLOWING TYPES OF INFORMATION CONTAINED IN THE PATIENT'S MEDICAL RECORDS (PLEASE INITIAL THE APPROPRIATE CATEGORIES LISTED BELOW):

_____ HIV/AIDS INFORMATION

_____ MENTAL HEALTH INFORMATION

_____ SUBSTANCE ABUSE INFORMATION

_____ SEXUALLY TRANSMITTED DISEASE INFORMATION

AT ALL TIMES, PATIENT RETAINS THE RIGHT TO REVOKE THIS CONSENT. SUCH REVOCATION MUST BE SUBMITTED TO THE PRACTICE IN WRITING. THE REVOCATION SHALL BE EFFECTIVE EXCEPT TO THE EXTENT THAT THE PRACTICE HAS ALREADY TAKEN ACTION IN RELIANCE ON THE CONSENT.

THE PRACTICE MAY REFUSE TO TREAT PATIENT IF HE/SHE (OR AN AUTHORIZED REPRESENTATIVE) DOES NOT SIGN THIS CONSENT FORM. IF PATIENT (OR AUTHORIZED REPRESENTATIVE) SIGNS THIS CONSENT AND THEN REVOKES IT, THE PRACTICE HAS THE RIGHT TO REFUSE TO PROVIDE FURTHER TREATMENT TO PATIENT AS OF THE TIME OF REVOCATION (EXCEPT TO THE EXTENT THAT THE PRACTICE IS REQUIRED BY LAW TO TREAT INDIVIDUALS).

I HAVE READ AND UNDERSTAND THE INFORMATION IN THIS CONSENT. I HAVE, IF REQUESTED, RECEIVED A PAPER COPY OF THIS CONSENT, AND I AM THE PATIENT OR AM AUTHORIZED TO ACT ONBEHALF OF THE PATIENT TO SIGN THIS DOCUMENT VERIFYING CONSENT TO THE ABOVE STATED TERMS.

_____ _____

SIGNATURE OF __PATIENT__AUTHORIZED REPRESENTATIVE* **DATE**

_____ _____

PRINTED NAME ***IF AUTHORIZED REPRESENTATIVE, RELATIONSHIP TO PATIENT**

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CONSENT FOR MRI EXAMINATION

Patient Name: _____ **DOB:** _____

Authorization To Use, Obtain and Disclose Health Information

I have read and understand The MRI Center Notice of Privacy Practices. I authorize The MRI Center to use, obtain and disclose specific health and medical information regarding my treatment for the purposes described to/from my insurance company, my primary care physician, area hospitals and facilities and other health care providers. I acknowledge that I am responsible for providing and updating my insurance, demographic, primary care physician as well as other care providers to The MRI Center.

Initial _____

Consent for Treatment

I hereby give my consent to perform MRI examination(s) as deemed necessary by my physician. (Should the patient be a minor or legally impaired, a signature of a parent or legal guardian is required before imaging can be started.)

Initial _____

Irrevocable Assignment of Benefits

I hereby assign to The MRI Center any benefits under any policy or other payor for my MRI examination(s). I hereby authorize this provider to allow my signature of endorsement to checks made payable to provider only and myself for procedures rendered to me by The MRI Center. I fully understand that I am directly and fully responsible to The MRI Center for all charges incurred for MRI examination(s). Initial _____

Radiological-Surgical Correlation As part of our ongoing commitment to quality patient care, we conduct regular radiological-surgical correlation. I authorize the release of pertinent surgical reports (if applicable) to The MRI Center for this purpose.

Initial _____

Medical Release & Payment Authorization

I authorize release of any medical information necessary to interpret this study and process this claim. I certify that the foregoing statements are true and correct. I authorize payment of medical benefits to the interpreting physician or supplier for services rendered. I understand that I am fully responsible to the interpreting physician for charges not covered by my insurance

Initial _____

Financial

I hereby assign, transfer and set over to The MRI Center all my interest to medical reimbursement benefits under my insurance policy. Furthermore, I attest that I have provided accurate and reliable insurance information to The MRI Center. And, regardless of insurance coverage, I acknowledge that I am financially responsible for all services provided. Initial _____

Permission To Give Medical Information

I hereby authorize the physicians and staff of The MRI Center to give information concerning my health and wellbeing to the person(s) listed below. Including, appointment times, test/lab results, medication, procedures and any information regarding my health.

Patient/Guardian Signature _____ Date_____