



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: _____
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 Health Images. I authorize the release of any medical information necessary for treatment by my current or future physician or healthcare provider.

I authorize Health Images 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 Health Image's Privacy Notice.

Printed Name: _____

Signature: _____ Date: _____



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

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