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 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 ORHAVE 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

INFORMED CONSENT FOR
MRI WITH OR WITHOUT CONTRAST INJECTION

PATIENT NAME:____

I, the undersigned, being either the patient named above or legally authorized representative of the patient named above, do hereby consent to the performance of medical diagnostic and imaging procedures on the terms and conditions more fully set out below. I understand that I have the right to be informed about the diagnostic imaging procedure being used so that I may make the decision whether or not to undergo the procedure.

1. Consent to Imaging Procedure: Your attending physician believes it beneficial for you to undergo a diagnostic imaging procedure known as magnetic resonance imaging (MRI) to obtain additional information that may aid in diagnosing and treating your medical condition. It has been explained to me that MRI does not use x-rays or radiation. Instead a magnetic field and radio waves are used to create an image of internal body structures. MRI is a painless procedure that only requires that you lie quietly on a padded table that gently glides you into the magnet. While the scanner is performing your scan, you will hear some humming and thumping sounds. These are normal and should not worry you. In some cases, a contrast agent may be injected into your vein in order to give a clearer image of the area being examined. The MRI study may be conducted without the injection of contrast, but the images may not be as helpful to the radiologist and your physician. Inform the technologist if you wish to refuse the contrast injection.

2. Because of the magnetic field and radio frequencies, people with a heart pacemaker, brain aneurysm clips, and some implanted metallic or electrical devices should not have an MRI. It is important that you inform the technologist if you have any of these metallic appliances. Please inform the technologist if you are pregnant or think that you may be pregnant.
3. Potential Risks: Anytime an injection is given there is the potential for bruising or swelling at the injection site. Occasionally, minor allergic reactions occur in the form of itching, sneezing, hives, swelling of the eyes, wheezing or nausea. These symptoms may require treatment with medication we have at hand. Rarely, a more serious reaction will occur. A radiologist will evaluate the situation and determine if additional medical treatment is necessary. Even though it is rare, medical statistics indicated that a fatality might occur from the injection of contrast. If you have had a reaction to a sickle cell anemia or kidney disorder, are pregnant or breast feeding, you MUST inform the technologist.
4. 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 MRI 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, and 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**