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 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.