ENVISION IMAGING

Registration Form

PATIENT INFORMATION

Patient Last Name_____ First _____ MI _____

Address_____

City _____State _____Zip_____

Home Phone_____ Cell Phone_____

Social Security #_____DOB_____ Marital Status _____

Employer Name_____ Job Title _____

Employer Address_____ Work Phone _____

Employer City_____State_____Zip_____

Emergency Contact

Name _____Phone_____

Address_____

POLICY HOLDER INFORMATION

☐ please check if same as above

Name _____Address_____

Relationship_____SSN_____DOB_____

Employer_____Phone_____

Address_____

On the Job Injury? ☐Yes ☐No DOI_____Motor Vehicle Accident? ☐Yes ☐No Date_____

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 of North Fort Worth. I authorize the release of any medical information necessary for treatment by my current or future physician or health care provider via mail, email, fax, or website. I authorize Envision Imaging of North Forth Worth to release to my insurance company any medical information which may be necessary to process my insurance claims. I understand that in the event my insurance company denies the claim, I will be held financially responsible for all charges.

I acknowledge that I have received a copy of Envision Imaging North Fort Worth's Privacy Notice. Initials _____

Print Name _____

Signed _____ Date _____

Ultrasound History & Screening Form

Date: _____/_____/_____Patient: _____Sex: M F

Age: _____ DOB _____/_____/_____Weight: _____Height:_____

**********Female Patients Only**********
First day of Last Menstrual Cycle: _____

How many times have you been pregnant? _____

How many children have you delivered? _____
****

Why are you having this test today?

_____

_____

Have you had previous imaging related to this problem? Yes: _____ No:_____

If Yes, where was the exam performed? _____

List any other medical problems: _____

_____

List all previous surgeries: _____

_____

List all allergies: _____

_____

Technologist Notes: _____

_____

I have answered these questions to the best of my knowledge and understand the information presented to me.

_____ Date: _____
Patient/Parent/ Legal Guardian Signature

_____ Date: _____
Technologist Signature

Envision Imaging NFW
4232 Heritage Trace Parkway
Keller, TX 76248
817-741-0008

Informed Consent for Ultrasound / Sonogram

Patient Name: _____ DOB: _____

Your physician has requested that we perform an ultrasound/sonogram (US) to obtain additional information. This is a diagnostic test that uses sound waves and a computer to produce images of internal body parts.

The benefit of this exam is to assist your physician with making a diagnosis. There may be other imaging alternatives, however, your physician believes that a sonogram to be the best diagnostic test for you after evaluating your symptoms and medical condition at this time.

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. 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

Additional Technologist Notes

ENVISION IMAGING
PATIENT AUTHORIZATION FOR SHARING
PROTECTED HEALTH INFORMATION WITH ANOTHER PERSON

PATIENT NAME: _____

DATE OF BIRTH: _____

ADDRESS: _____

PHONE: _____

As our patient, you may request that another person have access to part or all of the information contained in your medical record. For example, some patients choose to give access to a family member who helps the patient with health care decisions.

If you would like to do this, you must complete this form.

To whom should we give access to your information? _____

_____

Generally, we will give access to all the information we can. Should we give access to all the information we can? Or should we give access to just some types of information, like when a scan was performed?

a. Give access to all of the information you can.
b. Give access to only the following types of information.

_____
_____

For how long should we give this person access to your information?

c. Forever
d. From today until _____(please insert date)
e.

Patient Signature _____ Date: _____

RECORD ACTION TAKEN HERE

Envision Compliance Hotline
719-955-4337
complianceofficer@envisionradiology.com