REGISTRATION INFORMATION

PATIENT INFORMATION (PLEASE USE FULL LEGAL NAME)

Last: ______________ First: ______________ MI: ______ Sex: ______

Address: ______________________________

City: ______________ State: ______ Zip: ______

Home Phone: ______________ Other Phone: ______________ DOB: ______

Social Security#: ______________ Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Employer: ______________ Job Title: ______________

Employer Address: ______________ Work Phone: ______________

Emergency Contact Name: ______________________________

Emergency Contact Phone number: ______________________________

RESPONSIBLE PARTY INFORMATION

Last: ______________ First: ______________ Relationship to Patient: ______________

Address: ______________ Social Security #: ______________

DOB: ______________ Employer: ______________

Employer Address: ______________ Phone Number ______________

INSURANCE INFORMATION

On the job injury: ______ Motor Vehicle Accident: ______

Primary Insurance

Insurance Company: ______________ Address: ______________

City: ______________ State: ______ Zip: ______ Phone: ______________

Policy Holder: ______________ Policy #: ______________ Group Number: ______________

Adjuster: ______________________________

Secondary Insurance

Insurance Company: ______________ Address: ______________

City: ______________ State: ______ Zip: ______ Phone: ______________

Policy Holder: ______________ Policy #: ______________ Group Number: ______________

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. Initial ______________

Signature ______________________________ Date ______________

CT and IV Contrast History & Screening Form

DATE ________________________________

PATIENT ____ **SEX**: ☐ M ☐ F

WEIGHT ________ **HEIGHT** __________ **DOB** _____/____/______ **AGE** __________

Explain in detail your medical problem that is the reason for the CT Scan test today. (Where is the problem? How long have you had this problem?)

Have you had a previous exam 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:

CONTRAST HISTORY

Are you taking Glucophage, Glucovance, Metformin, Actos Plus Met, Avandamet, Fortamet, Metaglip, Glumetza, Riomet, or Janumet? ☐ YES (If yes, Circle Medication above) ☐ NO

List of other Medications? ____

Have you ever had an allergic reaction to an X-Ray/CT contrast? ☐YES ☐ NO

If Yes, please explain: ____

Any **personal** history of:

Asthma	☐ YES	☐ NO
Diabetes	☐ YES	☐ NO
Kidney Disease	☐ YES	☐ NO
Cancer	☐ YES	☐ NO
Multiple Myeloma	☐ YES	☐ NO
Are you on any blood thinners?	☐ YES	☐ NO
Blood Transfusions?	☐ YES	☐ NO
Currently on Dialysis?	☐ YES	☐ NO

FEMALE PATIENTS

Is there any possibility of pregnancy? ☐ YES ☐ NO ________Initial

Are you currently breast feeding? ☐ YES ☐ NO

Comments:

I have answered these questions to the best of my knowledge and understand the information presented to me. I have also informed the technologist that I am not pregnant at this time.

PATIENT/PARENT/LEGAL GUARDIAN SIGNATURE   TECHNOLOGIST/WITNESS SIGNATURE   DATE

NOT APPLICABLE TO THIS EXAM ☐

______ cc of ____________________ ____________________ ____________ ______________

Amount *Type of Contrast* *# of Punctures* *Lot #* *Expiration Date*

CONTRAST REACTION: ☐YES ☐NO Physician Covering Contrast: ___________________ Tech Initials: __________

EXPLAIN:

INFORMED CONSENT FOR CAT SCAN (With or Without Contrast Injection)

Patient Name:____

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 a computerized tomography scan (CT) to obtain additional information. This is a diagnostic test that uses x-ray and a computer to produce images of internal body parts.

As part of your examination, we may need to inject you with a contrast solution containing iodine. This clear, colorless liquid is removed from your body by your kidneys and will not alter the appearance of your urine. It will show up on the images to provide important diagnostic information.

Soon after the injection you may experience a metallic taste and a warm sensation. You may feel some nausea. These feelings last only a short time.

Occasionally, minor allergic reactions occur in the form of itching, sneezing, hives, swelling of the eyes or wheezing. These symptoms may require treatment with medication we have on hand. It is very important that you inform the technologist if you experience any of the conditions mentioned in this form.

Rarely, a more serious reaction will occur. Even though it is extremely rare, medical statistics indicate that a fatality may occur from the injection of contrast. If you have had a reaction to a contrast injection previously or a history of asthma or other allergic conditions, any history of diabetes or any kidney disorder, anemia or sickle cell anemia, if you are taking Glucophage, are pregnant or breast feeding, you MUST inform the technologist.

Blood Laboratory results may be needed before we can perform this exam. If we are unable to obtain lab results from your physician that are no greater than 6 weeks old, the Blood Lab testing will be performed at our center before your examination.

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 CAT scan 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, 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** ____________ **Time** __________

Patient/Parent/Legal Guardian Signature

______________________________ **Date** ____________ **Time** __________

Witness Signature

NOTICE OF PRIVACY PRACTICES

Published and Effective: on/or before April 14, 2003
Revised: 7/2013

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices is not an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. Protected Health Information (PHI) is information about you including demographic information that may identify you and that relates to your past, present and future physical or mental health condition (if applicable) and related health care services.

This Notice will be effective for all PHI that we maintain at this time. You may obtain any revised Notice of Privacy Practices by contacting our office to request a revised copy to be sent to you or coming by our office and asking for one.

USES AND DISCLOSURE OF PHI:

We collect health information from you and store it in an x-ray folder, on computer storage devices. This is your medical record. Your medical record is the property of Health Images, but the information in the medical record belongs to you. Health Images protects the privacy of your PHI. The law permits Health Images to use or disclose your PHI for the following purposes:

Treatment: We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with another provider. For example, we will disclose PHI to other physicians who may be treating you.

Payment: Your PHI will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may require before it approves or pays for the health care services that have been requested by your physician (e.g., making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities).

Health Care Operations: We may use and disclose, as needed, your PHI in order to support the business activities of our company and our affiliates. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, fundraising activities, and conducting or arranging for other business activities.

We will share your PHI with third party "business associates" who, in turn, may disclose this information to subcontracting business associates that perform various activities (for example,

billing or transcription services) for our company. Whenever an arrangement between our office and a business associate involves the use or disclosure of your PHI, we will have a written contract that contains terms that will protect the privacy of your PHI and the business associate will have a contract with their subcontracting business associates.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Agree or Object: We may use or disclose your PHI in the following situations without your authorization or providing you the opportunity to agree or object. These situations include: as Required By Law, Public Health Risks issues for purposes related to preventing or controlling disease, injury or disability; reporting elder or child abuse or neglect; reporting domestic violence. Reporting to the Food and Drug Administration (FDA) regarding adverse events, product defects or problems, or to conduct post marketing surveillance, as required. In the event of Legal Proceedings we may disclose PHI in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), or in certain conditions in response to a subpoena, discovery request or other lawful process. Releasing PHI to Law Enforcement so long as applicable legal requirements are met, for law enforcement purposes. Criminal Activity disclosure will be made as long as it is consistent with applicable federal and state laws, we may disclose your PHI, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. Military Activity and National Security when the appropriate conditions apply, we may use or disclose PHI of individuals who are Armed Forces personnel as required by military command authorities. We may disclose your PHI as authorized to comply with workers' compensation laws and other similar legally-established programs. In the event that Health Images is sold or merged with another organization, your health record will become the property of the new owner.

For Data Breach Notification Purposes: You will be notified immediately if an unauthorized acquisition, access, use or disclosure of your PHI resulting in the compromise or security of your PHI (a "breach") is detected. We will follow the Department of Health and Human Services' Breach Notification Rule (74 FR 42740), which includes timing, method and content requirements for breach notification.

Uses and Disclosures of PHI Based upon Your Written Authorization: Other uses and disclosures of your PHI not specifically described in this notice will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization in writing at any time. Please understand that we are unable to take back any disclosures already made with your authorization, and we are required to keep records of the care that we provided to you. We must obtain your written authorization before disclosing your PHI in the following situations:

- Prohibit the sale of your PHI – A "sale" of PHI includes any disclosure of PHI in exchange for remuneration, even if the ownership of the PHI remains with our company.

You have the opportunity to agree or object to the use or disclosure of all or part of your PHI. We may use and disclose your PHI in the following instances:

<u>Others Involved in Your Health Care or Payment for your Care:</u> Unless you object, we may disclose to a member of your family, a relative, a close friend or, any other person you identify, your PHI that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death.

<u>You have the right to inspect and copy your PHI:</u> This means you may inspect and obtain a copy of PHI about you for so long as we maintain the PHI in the form and format in which you request it, including electronically if readily producible in the requested format within thirty (30) days of our receipt of your written request, unless extended by agreement to sixty (60) days. You may obtain your medical record that contains medical and billing records and any other records that we use for making decisions about you. As permitted by federal or state law, we may charge you a reasonable copy fee for a copy of your records.

Under federal law, however, you may not inspect or copy the following records: information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding that are subject to law that prohibits access to PHI. Please contact our Privacy Officer if you have questions about access to your medical record.

<u>You have the right to request a restriction of your PHI:</u> You may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or health care operations. You may restrict disclosure to your health plan for services for which you pay out of pocket. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. *If you would like to request a restriction of your PHI, please ask our front desk staff to provide you with a Request For Restriction form.* Your request must state the specific restriction requested and to whom you want the restriction to apply.

<u>You have the right to request to receive confidential communications from us by alternative means or at an alternative location:</u> We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. Please make this request in writing to our Privacy Officer.

<u>You may have the right to have us amend your PHI:</u> This means you may request an amendment of PHI about you in a designated record set for so long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record.

<u>You have the right to receive an accounting of certain disclosures:</u> You have the right to receive an accounting of disclosures, paper or electronic, except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; to family members or friends involved in your care. You have the right to specific information regarding these

disclosures that occur after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us: You may ask for a copy this Notice at any time. You may view a copy of this Notice on our website at www.envrad.com. If you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice.

Confidentiality and Security: We maintain physical, electronic and procedural safeguards in compliance with state and federal standards to guard your PHI and personal financial information. These measures include computer safeguards, file security, and restrictions on who may access your information.

Changes to this Notice: We reserve the right to amend this Notice of Privacy at any time in the future. Until such amendment is made, Health Images is required by law to comply with this Notice. In the event there is a material change to this Notice, the revised Notice will be made available. In addition, you may request a copy of the revised Notice at any time.

Complaints: You may file your complaint with our center Manager or with our Privacy Officer. You may file a complaint with the Secretary of Health and Human Services if you believe we violated your privacy rights in any way. We will not retaliate against you for filing a complaint.

You may contact Privacy Officer/Compliance Specialist Tiffany Haywood-Henry at (719) 955-4337 or via email at complianceofficer@envisionradiology.com for further information about the complaint process.

Please be sure to initial the bottom of the Patient Registration Information form indicating that you read or were given the opportunity to receive a copy of our Notice of Privacy Practices. Please note that by initialing you are only acknowledging that you have read or been given the opportunity to receive a copy of our Notice of Privacy Practices.