PATIENT REGISTRATION INFORMATION

Today's Date: ____/____/____ Referring Physician: _____

Patient Information

Last name: _____ First name: _____ Middle Initial: ____

Social Security # _____ Sex: Male ( ) Female ( ) Date of Birth: ____/____/____

Address: _____ Apt # _____

City, State, ZIP Code: _____

Home Phone # _____ Alt. /Cell # _____

Emergency Contact: Name _____ Relationship_____

Home Phone # _____ Alt. /Cell # _____

Patient's Employment: Full Time____ Part Time ____ Retired ____ Not Employed ____ Student____

Employer: _____ Work phone # _____

Address: _____

Primary Insured: _____ Self (Skip to Primary Insurance Section)

Name & Relationship to Patient: _____ Date of Birth: ____/____/____

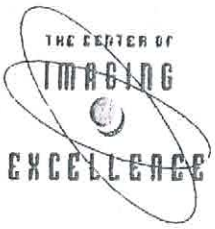
Primary Insurance: _____

Policy # _____ Group # _____

Secondary Insurance: _____

Policy # _____ Group # _____

2003–A Whitesburg Drive, Huntsville, AL 35801 –Phone (256) 536-3550 Fax (256) 536-3554



PATIENT AGREEMENT AND ACKNOWLEDGEMENT FORM

I understand payment of all insurance benefits for this period of service must be made directly to The Center of Imaging Excellence. If a check must be made out to me, I understand that the check must be sent to The Center of Imaging Excellence at the address listed at the bottom of this page.

Initial _____

I understand The Center of Imaging Excellence must collect for all the charges not covered by insurance payment. Payment for all collection costs is the financial responsibility of the patient or guardian. Patients who are considered a legal adult are financially responsible for all services rendered.

Initial _____

I hereby consent to The Center of Imaging Excellence to render usual and customary medical/emergency treatment, including diagnostic and radiological procedures, minor surgical procedures and administration of local anesthetics as necessary and any other general medical/emergency treatment and hospital care considered advisable or necessary by the physician.

Initial _____

Acknowledgement to use and disclose health information for treatment, payment, or healthcare operations (HIPAA pamphlet available on the front desk counter). I understand and have been offered a copy of the Privacy Practices of The Center of Imaging Excellence.

Initial _____

I have read and do understand the above statements and I have willingly signed.

_____ _____

Signature of the Patient / Guardian Date

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MRI PATIENT SCREENING FORM

Weight: _____ Duration of pain:_____

Have you ever had surgery on the area we are scanning today? Y N

If yes, date & type_____

Have you had a prior diagnostic imaging study or exam on the area we are scanning today? Y N

If yes, please list date and facility below:

MRI_____

CT_____

Other_____

Have you had an injury to the eye involving a metallic object or fragment? Y N

If yes, please describe_____

Have you ever had cancer? Y N

If yes, what type of cancer/location on the body_____

Date of Diagnosis_____ Treatment_____

Do you have or have you had:

Pace maker	Y N	Hearing Aid	Y N
Heart/Chest Surgery	Y N	Drug Infusion Pump (insulin pump)	Y N
Aneurysm Clips	Y N	Medication Patch	Y N
Brain Surgery	Y N	Dentures/Partials	Y N
Implant or Prosthesis	Y N	Metallic fragment or foreign objects	Y N
Neurostimulator	Y N	Are you pregnant or breastfeeding	Y N
Cochlear or other ear implant	Y N	Breast Tissue Expanders	Y N

Reason for MRI and /or Symptoms_____

_____

Patient Signature: X_____ Technician: X_____