PATIENT INFORMATION			
Last Name	First	M.I.	Sex
Street Address		Apartment/Unit #	
City	State	ZIP	
Home Phone	Mobile Phone		
Date of Birth	Social Security #	Marital Status	
Employer	Work Phone		
Emergency Contact Name	Phone		
Referred By			

FOR OFFICE USE ONLY	
INSURANCE (PRIMARY)	**(SECONDARY)**
Insurance Plan	Insurance Plan
ID	ID
Group	Group
Guarantor	Guarantor
DOB	DOB
Employer	Employer
WORK COMP/ATTORNEY/NO FAULT/PERSONAL INJURY	
Company	
Adjuster	Phone Number
Mailing Address	PO Box/ Suite
City	State/Zip
Claim #	DOI

DISCLAIMER AND SIGNATURE

I hereby request that payment of insurance benefits be made directly to Professional Imaging, LLC, on my behalf for any services provided to me. I acknowledge and understand that I am financially responsible for all charges related to service(s) rendered to me or dependent. If, for any reason, my insurance carrier does not pay any portion of my bill, I agree to make arrangements for prompt payment of my bill.

I have received and or been offered the Notice of Privacy Practices. I hereby authorize Professional Imaging,roteted Health Information (PHI) contained in my medical record to my treating physician, insurance company, attorney, and immediate family on behalf of myself and/or my dependents for the purpose of Treatment, Payment and Operations (TPO).

I authorize any physician or other health care providers participating in my treatment to provide copies of any medical records regarding me to each other.

Signature	Date

CONTRAST CONSENT FORM

HAVE YOU EVER HAD AN X-RAY OR CT SCAN DYE INJECTION			☐ YES	☐ NO	
HAVE YOU EVER HAD AN MRI SCAN DYE INJECTION			☐ YES	☐ NO	
Did you have any complications with any of the above injections			☐ YES	☐ NO	
If yes, please explain					
DO YOU HAVE A HISTORY OF SENSITIVITY TO IODINE			☐ YES	☐ NO	
DO YOU HAVE ANY ALLERGIES TO MEDICATION			☐ YES	☐ NO	
If yes, please explain					
HAVE YOU EVER HAD AN ANAPHYLACTIC REACTION OR AN ALLERGIC REACTION THAT REQUIRED MEDICAL ATTENTION (Anaphylactic reaction is an allergic reaction with difficulty breathing, closing of the throat, or swelling of the mouth or throat)			☐ YES	☐ NO	
If yes, please explain					
DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING					
Heart Problems	☐ YES	☐ NO	Diabetes	☐ YES	☐ NO
Lung Problems	☐ YES	☐ NO	Asthma	☐ YES	☐ NO
Kidney Disease	☐ YES	☐ NO	Sickle Cell Disease	☐ YES	☐ NO
Kidney Failure	☐ YES	☐ NO	Multiple Myeloma	☐ YES	☐ NO
If yes, please explain treatment					
ARE YOU TAKING ANY BLOOD THINNERS					
If yes, please explain					
ARE YOU CURRENTLY TAKING ANY OF THE FOLLOWING					
Glucophage	☐ YES	☐ NO	Metaglip	☐ YES	☐ NO
Avandamet	☐ YES	☐ NO	Glucovance	☐ YES	☐ NO
Metformin	☐ YES	☐ NO			
FEMALES ONLY	ANY POSSIBILITY OF PREGNANCY			☐ YES	☐ NO
FEMALES ONLY	ARE YOU CURRENTLY BREASTFEEDING			☐ YES	☐ NO

The above information is correct to the best of my knowledge.

Patient Signature _____

MRI SAFETY CHECKLIST

HAVE YOU HAD ANY SURGICAL PROCEDURES IN THE PAST 6 WEEKS		☐ YES	☐ NO
DO YOU HAVE A CARDIAC (HEART) PACEMAKER OR WIRES		☐ YES	☐ NO
DO YOU HAVE AN INTERNAL CARDIAC (HEART) DEFIBRILLATOR		☐ YES	☐ NO
DO YOU HAVE AN ARTIFICIAL HEART VALVE		☐ YES	☐ NO
DO YOU HAVE AN ANEURYSM CLIP OR METAL CLIP IN YOUR BODY OR HEART		☐ YES	☐ NO
DO YOU HAVE AN IMPLANTED NEUROSTIMULATOR (TENS) UNIT		☐ YES	☐ NO
DO YOU HAVE ANY TYPE OF BIO/BONE GROWTH/DEEP BRAIN STIMULATOR		☐ YES	☐ NO
DO YOU HAVE ANY INTRAVASCULAR STENTS/FILTERS/COILS		☐ YES	☐ NO
DO YOU HAVE ANY ORTHOPEDIC IMPLANTS, IE. PINS/PLATES/SCREWS/WIRES		☐ YES	☐ NO
DO YOU HAVE ANY ARTIFICIAL OR PROSTHETIC LIMBS		☐ YES	☐ NO
DO YOU HAVE ANY ORBITAL OR EYE PROSTHESIS		☐ YES	☐ NO
DO YOU HAVE ANY EAR PROSTHESIS OR COCHLEAR IMPLANTS		☐ YES	☐ NO
HAVE YOU EVER HAD EAR SURGERY		☐ YES	☐ NO
HAVE YOU EVER HAD AN INJURY TO THE HEAD OR EYES BY METAL		☐ YES	☐ NO
DO YOU HAVE ANY VASCULAR ACCESS PORTS		☐ YES	☐ NO
DO YOU HAVE ANY PERMANENT MAKEUP		☐ YES	☐ NO
DO YOU HAVE ANY BODY PIERCINGS		☐ YES	☐ NO
DO YOU WEAR A HEARING AID		☐ YES	☐ NO
HAVE YOU SWALLOWED A GASTRIC CAPSULE CAMERA IN THE PAST WEEK		☐ YES	☐ NO
ARE YOU CURRENTLY WEARING A MEDICATION PATCH		☐ YES	☐ NO
ARE YOU CURRENTLY WEARING AN INSULIN OR PAIN MEDICATION PUMP		☐ YES	☐ NO
DO YOU CURRENTLY HAVE A TISSUE EXPANDER IMPLANT		☐ YES	☐ NO
FEMALES ONLY	IS THERE A POSSIBILITY YOU COULD BE PREGNANT	☐ YES	☐ NO
FEMALES ONLY	ARE YOU CURRENTLY BREASTFEEDING	☐ YES	☐ NO
FEMALES ONLY	DO YOU HAVE AN INFLATABLE BREAST IMPLANT	☐ YES	☐ NO
MALES ONLY	DO YOU HAVE A PENILE PROSTHESIS	☐ YES	☐ NO

The above information is correct to the best of my knowledge.

Patient Signature _____

PATIENT CLINICAL QUESTIONNAIRE

All questions are pertaining to exam(s) being performed today

ANSWER ALL QUESTIONS TO THE BEST OF YOUR KNOWLEDGE. THIS FORM WILL BE SUBMITTED TO YOUR INSURANCE COMPANY FOR BILLING PURPOSES

NAME:	**DOB:**
HEIGHT:	**WEIGHT:**
POSSIBILITY OF PREGNANCY?	**BREASTFEEDING?**

Describe your symptoms, location of the pain, cause of accident and date of injury.

_____
_____
_____
_____
_____

Have you had surgery on the area being scanned? □ Yes □ No If yes, please list dates and description.

_____
_____
_____

Have you had prior diagnostic testing (X-rays, CTs, MRIs) on the area being scanned? □ Yes □ No If yes, please list dates and exam type.

_____
_____
_____

Have you had chemotherapy or radiation therapy in the area being scanned? □ Yes □ No If yes please list dates.

_____
_____
_____

Check all that apply

Neck Pain	□ Right □ Left
Arm Pain	□ Right □ Left
Arm Weakness	□ Right □ Left
Arm Numbness	□ Right □ Left
Arm Tingling	□ Right □ Left
Back Pain	□ Right □ Left
Leg Pain	□ Right □ Left
Leg Weakness	□ Right □ Left
Disease	
Leg Numbness	□ Right □ Left
Leg Tingling	□ Right □ Left

Do you have any of the following medical conditions?

□ Asthma	□ Heart Disease
□ Bells Palsy	□ Hysterectomy
□ Bleeding Disorder	□ Kidney Disease
□ Blurred Vision	□ Liver Disease
□ Buzzing/Ringing in Ears	□ Lung Disease
□ Cancer	□ Multiple Myeloma
□ Diabetes	□ Memory Loss
□ Hearing Loss	□ Pancreatic
□ Headaches	□ Prostate Disease
□ Head Trauma	□ Seizures
□ TMJ Problems	□Vertigo
□ Gall Bladder Disease	

ASSIGNMENT OF BENEFITS

I hereby request that payment of insurance benefits be made directly to Professional Imaging, on my behalf for any services provided to me. I acknowledge and understand that I am financially responsible for all charges relating to the service(s) rendered to my dependent to me. If, for any reason my insurance carrier does not pay any portion of my bill, I agree to make arrangements for prompt payment of my bill.

CONSENT FOR RELEASE OF PROTECTED HEALTH INFORMATION

PLEASE CIRCLE ONE

YES NO I have received the Notice of Privacy Practices and am aware of the following:

1. I have the right to place restrictions on the way my Protected Health Information (PHI) is used or disclosed. Professional Imaging is not required to agree with my requested to agree with my requested restrictions. Once Professional Imaging agrees to my restrictions, it will comply with those restrictions.

2. I have a right to revoke my consent for the use and disclosure of my protected health information at any time. I understand that, if I choose to revoke my consent, I will submit a written statement to Professional Imaging that is signed by me. Upon receipt, Professional Imaging will immediately comply with my request to revoke consent, expect to the extent that is has already taken some action that was based on my original consent.

3. Professional Imaging has reserved the right to change from time to time its privacy practices that are described in its Notice of Privacy Practices. Whenever its privacy practices are changed, Professional Imaging will modify the Notice accordingly.

4. The Notice of Privacy Practices and Professional Imaging policies and procedures are based on the Healthcare Insurance Portability & Accountability Act of 1996 as amended periodically.

YES NO I hereby authorize Professional Imaging, to release Protected Health Information (PHI) contained in
my medical records to my treating physician, insurance company, attorney, and immediate family behalf of myself and/ or dependents for the purpose of Treatment, Payment and Operations (TPO)

Signed: _____ Date: _____

Patient Name (if different than the above signed): _____

NOTICE OF PRIVACY PRACTICES OF PROFESSIONAL IMAGING

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

USES AND DISCLOSURES OF HEALTH INFORMATION

Without your consent, we may use health information about you for treatment (such as sending your medical record information to a specialist physician as part of a referral), to obtain payment for treatment (such as sending billing information to a health insurance plan), and for administrative purposes (such as comparing patient data to improve treatment methods.)

We may also use or disclose identifiable health information about you without your authorization for several other reasons. Subject to certain requirements, we may disclose health information without your authorization for public health purposes, abuse or neglect reporting, auditing purposes, research studies, coroners, funeral arrangements and organ donation, workers' compensation purposes, judicial/ administrative proceedings/ specialized government functions to relatives/ friends involved in your treatment and payment for your treatment if you do not object, and in emergencies. We provide information when otherwise required by law.

We may also contact you about appointment reminders. If we cannot reach you regarding appointment reminders we may leave a limited message on your answering machine or with the person who answers your telephone. Please inform us if you do not want to receive appointment reminders in any of these ways. In any other situation, we ask you for a written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses or disclosures.

We may change our policies at any time. Before we make a significant change in our policy, we will change our Notice and post the new Notice in the waiting area, in each examination room, and on our website. You can also request a copy of our Notice at any time. For information about our privacy practices, contact the person listed below.

INDIVIDUAL RIGHTS:

In most cases, you have the right to look at or get a copy of health information about you that we use to make decisions about your care. An example of when you may not have access to your health information is when you are participating in a research study. You may receive access after the research study is complete. You also have the right to receive a limited list of instances where we have disclosed health information about you for reasons other than treatment, payment, or related administrative purposes. If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information.

You have the right to request that your health information be communicated to you in a confidential manner such as sending mail to an address other than your home. If this notice was sent to you electronically, you may obtain a paper copy of the notice.

You may request in writing that we not use or disclose your information for treatment, payment, or administrative purposes. We will consider your request but we are not legally required to accept it.

COMPLAINTS:

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. The person listed below can provide you with the appropriate upon request. Under no circumstances will you be retaliated against for filling a complaint.

OUR LEGAL DUTY:

We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices that are described in this notice.

If you have any questions or complaints regarding privacy,
Please contact:
Tyler Raasch (Office Manager) Telephone: (314) 743-2000

Patient Signature:_____ **Date:**_____