3100 Matlock Suite 105, Arlington, TX 76015
Phone 817-543-2412

PATIENT INFORMATION:_____JACKET#:_____PATIENT#_____

Last Name: _____ First Name**:**_____ Male____ Female____

Home Address: _____City: _____ State:_____ Zip: _____

Date of Birth:____/____/____ Age: ____ Social Security: _____-_____-_____ Marital Status:_____

Home Phone#: _____ Cell#: _____ E-mail: _____

Ethnicity:_____ Race:_____Preferred Language:_____Nationality:_____

Height:_____ Weight:_____ Driver's License #:_____ State Issued:_____

Do you smoke: _____ How many packs per day:_____ How long:_____ Ever smoked:_____

Emergency Contact Name: _____ Phone#_____

REFERRED BY:_____

Doctor:_____Phone #_____

Primary Care Physician: _____ Phone #_____

INSURANCE INFORMATION_____(please complete all information)_____

Insurance Co Name: _____ Phone #:_____

Claims filing Address:_____ City: _____ State:_____ Zip:_____

Subscribers/Guarantor Name: _____ Date of Birth: ____/___/____

Subscribers/Guarantor Address:_____ City: _____ State:_____ Zip: _____

Social Security: _____-_____-_____ Patients relationship to Subscriber: _____

Employer: _____ Employer Address:_____

Home Phone:_____Cell Phone: _____Driver's License #:_____State:_____

InsuranceIdentification#:_____ Group#:_____

SECONDARY INFORMATION_____

Insurance Co Name: _____ Phone#:_____

Claims filing Address:_____ City: _____ State:_____ Zip:_____

Subscribers Name: _____ Date of Birth: ____/___/____

Social Security: _____-_____-_____ Patients relationship to Subscriber: _____

Employer: _____ Employer Address:_____

Insurance Identification#:_____ Group#:_____

WORKERS COMP/ATTORNEY INFORMATION_____

Was this a result of a car accident?yes___ no___was this a result of a work related injury? yes __ no___

Workers Comp /Attorneys: Name _____Phone#: _____

Mailing Address:_____ City:_____ State:_____

WC Claim #_____

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MRI PATIENT HISTORY

Patient Name: _____ DOB_____

Please indicate Yes or No to the following questions. All questions must be answered.

	YES	NO
Are you taking any medication?	☐	☐
(If YES, what type?)_____		
Are you allergic to any medication?	☐	☐
(If YES, what kind?)_____		
Are you claustrophobic?	☐	☐
Do you or have you ever had:		
An MRI? *(If yes, Where and When?)_____	☐	☐
Cardiac Pacemaker?	☐	☐
Aneurysm Clips?	☐	☐
Metal in the eye?	☐	☐
Neuro Stimulator? (Tens-Unit)	☐	☐
Head Surgery?	☐	☐
Heart Attack?	☐	☐
Back Surgery? (If yes, at what level?) _____	☐	☐
Gunshot or shrapnel wound?	☐	☐
Any implanted electronic device?	☐	☐
Hearing Aid?	☐	☐
Ear Implant?	☐	☐
Lens Implant	☐	☐
Any type of metal in your body?	☐	☐
For contrast patients only:		
Do you have any blood disorders?	☐	☐
Do you have any allergies?	☐	☐
Have you ever been diagnosed or treated for sickle cell anemia?	☐	☐
Have you ever had an allergic reaction to any contrast?	☐	☐
Do you have asthma?	☐	☐
Do you have any heart conditions?	☐	☐
If Female		
Do you think you may be pregnant?	☐	☐
Do you have an IUD?	☐	☐
Are you breast-feeding?	☐	☐

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

Patient Signature _____ Date: _____

Witness Signature _____ Date: _____

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MEDICAL BACKGROUND

Briefly explain any problems you are experiencing: _____

_____

_____

Please indicate if you have ever experienced any major medical or surgical history: _____

_____

_____

Have you had any prior X-Rays pertaining to this condition? _____

If so, please indicate when & where: _____

_____

Date of Injury: _____

Please check type of accident: ☐ Motor Vehicle ☐ Work Related ☐ Other

Briefly explain: _____

_____

Please indicate if you have or are experiencing:

☐ Reaction to X-Ray Dye
☐ Cardiac Dysfunction
☐ Generalized Severe Debilitation (weakness)
☐ Asthma or Allergy
☐ Sickle Cell Disease

Signature: _____ **Date:** _____

*** For female patients only***

Date of last menstrual period: _____

Do you use any contraceptive? ☐ Yes ☐ No If so, what type? _____

Is there any possibility that you could be pregnant? ☐ Yes ☐ No

Tubal ligation? ☐ Yes ☐ No Date performed _____

Hysterectomy: Partial or Complete Date performed: _____

Signature: _____ **Date:** _____

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Radiology Films

I acknowledge that if previous films are not immediately available for comparison, this may delay interpretation of the study to be performed today, and if previous films cannot be located, interpretation of today's service may not be as reliable as would be anticipated had comparison films been available.

Additional Fees

To obtain a **personal** copy of images, **CD is $5.00** and **films are $8.00 per sheet.** To request your study be read on STAT basis (as soon as possible) this is not medically necessary or ordered by your doctor then it is a $30.00 fee.

All patients need to give a 24-hour notice to pick up CD or films.

Central Imaging of Arlington does not honor DNR.

Patient Signature _____ **Date:** _____

Witness Signature _____ **Date:** _____

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PATIENT CONSENT AND ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I understand that as part of the provision of health services, Central Imaging of Arlington creates and maintains health records and other information describing, among other things, my clinical history, symptoms, examination, results, diagnoses, treatment, radiology films, and any plans for further care or treatment.

I have been provided with a Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that Central Imaging of Arlington reserves the right to change their Notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations (quality assessment and improvement activities, underwriting premium rating, conducting or arranging for medial review, legal services, and auditing functions, etc.) and that Central Imaging of Arlington is not required to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment and healthcare operations. I have the right to revoke this consent, in writing, except where disclosures have already been made in reliance on my prior consent.

This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment of healthcare operations without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this consent is as valid as the original.
3. I have the right to request that the use of my protected health information, which is used or disclosed for the purposes of treatment or payment of healthcare operations, be restricted. I also understand that Central Imaging of Arlington and I must agree to any restriction in writing that I request on the use and disclosure of my Protected Health Information; and agree to terminate any restrictions in writing on the use and disclosure of my protected health information which have been previously agreed upon.

_____ _____

Signature of Patient **Date Signed**

_____

Patient's Name Printed Social Security Number Date of Birth

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AUTHORIZATION FORM FOR RELEASE/RECEIPT OF PROTECTED HEALTH INFORMATION

I, _____ , D.O.B., _____ SS# _____
(PRINT NAME)
hereby authorize Central Imaging of Arlington ("practice") to use, receive, and/or disclose the protected health information for billing and other purposes.

The person and/or facility to whom the information will be released to or received from: _____

_____

Central Imaging of Arlington is hereby authorized to receive and/or disclose to the aforementioned person and/or facility and the aforementioned person and/or facility is hereby authorized to use or disclose the information. This authorization shall be in force and effective for **one year from the date signed below**.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Dr. Phyllis Frostenson at Central Imaging of Arlington at P.O. Box 150268, Arlington, Texas 76015. I understand that a revocation is not effective to the extent that the practice has relied on this authorization in its action. Also, a revocation is not effective if this authorization was obtained as a condition of obtaining insurance coverage, as other law provides the insurer with the right to contest a claim under the policy or the policy itself.

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal HIPAA privacy regulations.

Central Imaging of Arlington will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

_____ _____
Signature of Patient or Personal Representative **Date**

_____ _____
Print Name of Patient or Personal Representative **Description of Personal Representative's Authority**