PI

Patient Information

(Please Print)

Patient's Name _____ Email _____

Date of Birth _____ Gender Male Female (Circle One)

Address _____

City _____ State _____ Zip _____

Home Phone _____ Alternate Phone _____

Social Security Number _____ Marital Status _____

Employer _____ Occupation. _____

Responsible Party _____ Relationship to Patient _____

Emergency Contact Phone Number _____

Insurance Information

Primary Insurance Company _____

Contract/Policy # _____ Group # _____

Subscriber Name _____

Subscriber Date of Birth _____ Relationship to Patient _____

Secondary Insurance Company _____

Contract/Policy # _____ Group # _____

Subscriber Name _____

Subscriber Date of Birth. _____ Relationship to Patient. _____

Please Read:

I authorize MED-Tech Imaging Center Inc., holder of medical or other information about me, to release to the social security administration and health care financing administration or its intermediaries or carriers any information needed for this or any and all insurance claims. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts the assignment. I understand it is mandatory to notify the health care provider of any other who may be responsible for paying for my procedures. I authorize Med-Tech Imaging Center Inc. to furnish the above information. I assign to Med-Tech Imaging Center Inc. payments for medical services rendered to my dependents or myself. I **understand I am financially responsible to MED-Tech Imaging Center Inc. for co-pays, deductibles and any charges not covered by my insurance provider and if this obligations is not paid in full when due, I agree to pay all costs of collecting it, including reasonable attorney's fee. You agree,** in **order for us to service your account or collect monies you may owe, we or a designated agent may run credit reporting as necessary, contact you by email or telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. Methods of contact include using email and pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable.**

Signature: _____ **Date** _____

MED-TECH Imaging Center
102 Medical Center Dr.
Prattville ,Alabama 36066

Patient Name:(please print)_____

Address: _____

I have received a copy of Med-Tech Imaging Center Inc. ***Notice of Privacy Practices*** on this date and have been given the opportunity to write down any restrictions that I would like to make on my Protected Health Information.

_____

_____

_____

_____

_____

_____

Signed: _____

Date:_____

********** PLEASE KEEP FOR YOUR RECORDS**********

This Notice Is effective as of May 2004.

THIS NOTICE DECRIBES HOW PROTECTED MEDICAL INFORMATIONABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION .PLEASE REVIEW.ITCAREFULLY.

1. Med-Tech Imaging Center Inc. is permitted to make use and disclosures of protected health information for treatment, payment and health care operations, described in the following examples:
   - For Treatment-The technologist will review your medical information and the scans of films along with a radiologist to ensure that a clinically appropriate resultwas obtained.
   - For Payment-Our office staff will relay information to your health insurance payer to obtain payment for the services providedto you here at the Center.
   - For health care operations-Periodic reviews by Med-Tech Imaging Center's staff on both your clinical and your financial information will be conducted to monitor for accuracy, safety and appropriateness.
   - For Health Care Providers-Our staff will relay information to any physician that you may see for treatment.

2. Med-Tech Imaging Center Inc. is permitted or required under specific circumstances to use or disclose protected health information without the Patient's written authorization .In addition to disclosures for treatment, payment and operations, Med-Tech Imaging Center Inc. may be required to make disclosures for purposes of worker's compensate-ion, public health, law enforcement or similar state or federal laws or ordinances.
3. Other uses and disclosures will be made only with the Patient's written authorization, and the Patient may revoke such authorization.
4. Med-Tech Imaging Center Inc. may contact the patient to provide appointment reminders or other health related benefits and services that may be of interest to the Patient.
5. The Patient has the following rights regarding protected health information:
   - The right to request restrictions on certain uses and disclosures of protected health information. **Med-Tech Imaging Center Inc. Is not required to agree to a requested restriction, however.**
   - The right to receive confidential communications of protected health information, as applicable.
   - The right to inspect and copy protected health information as provided in the Privacy Regulation.
   - The right to amend protected health information, as provided in the Privacy Regulation.
   - The right to receive an accounting of disclosures of protected health information.
   - The right to obtain a paper copy of the Notice from the covered entity upon the request. This right extends to a Patient who has agreed to receive the Notice electronically.
6. Med-Tech Imaging Center Inc. is required by law to maintain the privacy of protected health information and to provide Patients with notice of its legal duties and Privacy practices with respect to protected health information.
7. Med-Tech Imaging Center Inc. is required to abide by the terms of the Notice currently in effect.
8. Med-Tech Imaging Center Inc. reserves the right to change the terms of this Notice. The new Notice provisions will be effective for all protected health information that Med-Tech Imaging Center Inc. maintains.
9. Med-Tech Imaging Center Inc. will provide Patients with a revised Notice by providing copies of the revised Notice at Med-Tech Imaging Center Inc.'s reception desk.
10. Patients may complain to Med-Tech Imaging Center Inc. and to the Secretary of the Department of Health and Human Services, without fear of retaliation by Med-Tech Imaging Center Inc., if they believe their privacy rights have been violated. A brief description of how the Patient may file a complaint is as follows: Direct a written copy of the facts and allegations of your complaint to the attention of the **HIPPA Privacy Officer** at the address below or you may telephone the **HIPPA Privacy Officer** directly.
11. Med-Tech Imaging Center Inc. contact person for matters relating to complaints is:

Med-Tech Imaging Center Inc.
HIPPA Privacy Officer
Prattville ;Alabama 36066

********** * PLEASE KEEP FOR YOUR RECORDS******** **********

Authorization for Use and Disclosure of Protected Health Information

I, , hereby authorize Med-Tech Imaging Center Inc. to disclose the following protected health information to:

_____ _____

_____ _____

___Records-Reports related only to the following dates of service _____
___Records and original films related only to the following dates of service._____
____Complete medical history **(reports)** with High Tech Imaging Center Inc.

This protected health information is being released for the following purposes:

___Treatment by another physician other than the referring physician
____Transfer of records to complete health records or information at another entity other than the referring physician.
_Attorney
_Other_____

I understand that MED-Tech Imaging Center Inc. may release my medical records to any physician that I may be under the care of in the future.

I understand that I have a right to revoke this authorization, in writing, at any time by sending such written notification to the Privacy Officer at 102 Medical Center Dr. Prattville, Ala. I understand that a revocation is not effective to the extent that Med-Tech Imaging Center Inc. has relied on the use or disclosure of the protected health information. I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payment, and enrollment in a health plan, or eligibility for benefits.

I understand that 1. I have the right to inspect or obtain a copy of the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights) .2. Refuse to sign this authorization.

This authorization expires one-year from the date signed or the date the following event occurs:

_____
Signature of Patient or Personal Representative

_____
Patients Address

_____
Patient date of birth and social security number

MED-Tech Imaging Center

PATIENT STATEMENT OF PREGNANCY/ NURSING CONDITION

Patient: _____

In the interest of safety for unborn children and nursing infants, every female patient of childbearing age (10yrs-55yrs) is required to complete applicable portions of the following questionnaire.

NOTE: ALL STATEMENTS ARE CONSIDERED TO BE STRICKLY CONFIDENTIAL.

When was your last menstrual cycle? _____
Are you currently on any type of birth control medicine? Yes___ No___ what type? _____

* I am physically unable to become pregnant due to surgical/ medical procedures which have been performed.

_____
Initial if applicable
(If the above Is Initialed , omit the remaining questions and sign and date at the bottom of the page.)

* I am absolutely certain that I am not pregnant:

_____

Initial if applicable

* I know or believe that I am pregnant.

_____
Initial if applicable

*I am breastfeeding.

_____
Initial if applicable

* I am not breastfeeding.

_____

Initial if applicable_____

Patient Signature: _____
Date: _____

NOTES- Office *Use Only!!*

_____

_____

_____

_____

_____

MRI PATIENT HISTORY/ SAFETY SCREENING

NAME:_____ DATE OF BIRTH:_____

AREA TO SCAN:_____

DO YOU HAVE A FOLLOWUP APPT WITH YOUR PHYSICIAN CONCERNING TODAY'S EXAM? _____

IF YES, WHEN?_____

WEIGHT:_____ HEIGHT:_____

HAVE YOU HAD A PREVIOUS MRI OF THE AREA BEING SCANNED TODAY?_____ IF YES, WHEN AND WHERE:

_____

ARE YOU HAVING PAIN, WEAKNESS, OR NUMBNESS IN EITHER OF YOUR ARMS OR LEGS?_____

IF YES, PLEASE CIRCLE ALL THAT APPLY: RIGHT OR LEFT

LEG ARM OR LEG ARM

IS THIS AN INJURY RESULTING FROM AN ACCIDENT? _____ ACCIDENT DATE:_____

PLEASE CIRCLE IF YOU HAVE HAD SURGERY ON ANY OF THE FOLLOWING . IF YES, PLEASE INDICATE WHAT TYPE AND WHEN.

SKULL	y	N	If so, what type:_____
NECK/CERVICAL	y	N	If so, what type:_____
LUMBAR/LOWER BACK	y	N	If so, **what** type:_____
ABDOMEN	y	N	If so, **what** type:_____
OTHER	y	N	If so, what type:_____

HAVE YOU EVER HAD CANCER?_____ If so, what type:_____

ARE YOU **PREGNANT?**_____

*Because some metallic implants or items can interfere with or be hazardous to you during this study, please indicate that by circling all that apply on this list to determine whether there are any contraindications to you having this study. Also, please inform the technologist of this **BEFORE** your exam.*

Pacemaker	Hearing aids or implants	Shunts, Spinal, Ventricular
Aneurysm clips	Shrapnel, bullets	Intrauterine device
Heart valve/stents	Joint replacements	Bone or joint pins, wire sutures
Neuro-stimulator	Prosthesis	Metal in your eyes
Insulin/Pain Pump	Metal plates, pins, screws	Dentures, partials in mouth

If you circled any of the above, please explain:_____

_____

_____ DATE:_____

I HAVE READ AND UNDERSTAND ALL THE QUESTIONS PERTAINING TO MRI SCANNING.
SIGNATURE OF PATIENT OR GUARDIAN (IF MINOR)

Technologist : RT(R)(MR)_____

Rev 1.1

CII

CT QUESTIONAIRE/CONSENT FOR INTRAVENOUS INJECTION

MEDICAL HISTORY

PRESENT COMPLAINT_____

HAVE YOU EVER HAD CANCER? Y OR NO IF SO, WHAT TYPE?_____

HAVE YOU EVER HAD SURGERY? Y OR NO IF SO, WHAT TYPE?_____

HAVE YOU HAD A PREVIOUS CT? Y OR NO IF SO, WHAT TYPE?_____

ARE YOU DIABETIC? Y OR NO IF YES, MEDICATION?_____

PREGNANT? Y OR NO DATE OF LAST MENSTRATION?_____

DO YOU SUFFER FROM ANY OF THE FOLLOWING:

ASTHMA	Y	N	HEART DISEASE/CARDIAC CONDITION	Y	N
RENAL DISEASE	Y	N	ALLERGIC/RESPIRATORY DISEASE	Y	N
SEIZURE DISORDER	Y	N	ANEMIA	Y	N
LACTATION	Y	N	ALLERGIES TO MEDICATION	Y	N

IF YES, PLEASE LIST:_____

CURRENT PRESCRIBED MEDICATIONS YOU ARE TAKING?_____

Your physician has requested that you have a CT examination **WITH CONTRAST**. This will necessitate an intravenous injection of a paramagnetic enhancement contrast medium. The injection will be given into a vein, either in the hand or in the region of the elbow. **It is important to realize that without injection, abnormalities may be very difficult or impossible to detect.** There are NO known contraindications to the use of this material, however a small percentage of patients will experience a mild reaction in the form of nausea, vomiting and may experience the development of a transient headache. Other adverse reactions have been reported in less than 1% of the patients include: coldness, warmth, hypotension, agitation, dizziness, rash, sweating, ringing in the ears and dry mouth. These reactions are uncommon, transient and are self-limited. Should you experience any of these reactions, we shall treat them with the appropriate medical care using all good and acceptable medical judgment and procedures.

I acknowledge that I have read this document in its entirety, that I fully understand it, that all my questions have been answered to my satisfaction and that I agree and consent to the use of this diagnostic material.

Signed_____

Date_____

FOR OFFICE USE ONLY

DATE & TIME OF INJECTION_____ INJECTION SITE:_____

TYPE/AMOUNT OF CONTRAST INJECTED:_____ LOT:_____

SIGNATURE OF INJECTING TECH:_____ COMMENTS:_____

CONSENT FOR INTRAVENOUS MRI INJECTION

MEDICAL HISTORY

DO YOU SUFFER FROM ANY OF THE FOLLOWING:

ASTHMA	Y	N	HEART DISEASE/CARDIAC CONDITION	Y	N
RENAL DISEASE	Y	N	ALLERGIC/RESPIRATORY DISEASE	Y	N
SEIZURE DISORDER	Y	N			
ANEMIA	Y	N			
LACTATION	Y	N			
ALLERGIES TO MEDICATION			Y	N	

IF YES, PLEASE
LIST:_____

_____

Your physician has requested that you have a MRI examination **WITH CONTRAST**. This will necessitate an intravenous injection of a paramagnetic enhancement contrast medium. The injection will be given into a vein, either in the hand or in the region of the elbow. **It is important to realize that without injection, abnormalities may be very difficult or impossible to detect.** There are NO known contraindications to the use of this material, however a small percentage of patients will experience a mild reaction in the form of nausea, vomiting and may experience the development of a transient headache. Other adverse reactions have been reported in less than 1% of the patients include: coldness, warmth, hypotension, agitation, dizziness, rash, sweating, ringing in the ears and dry mouth. These reactions are uncommon, transient and are self-limited. Should you experience any of these reactions, we shall treat them with the appropriate medical care using all good and acceptable medical judgment and procedures. **There have been no reports of death as a result of this injection**. There is no alternate paramagnetic enhancement contrast media.

Signed_____

Date_____

FOR OFFICE USE ONLY

DATE & TIME OF INJECTION_____ INJECTION SITE:_____

TYPE/AMOUNT OF CONTRAST
INJECTED:_____LOT:_____

SIGNATURE OF INJECTING TECH:_____

COMMENTS:_____

_____