SPECTRUM MRI
FULL BODY IMAGING CENTER

DOCTOR'S LIEN
AND RELEASE OF MEDICAL DOCUMENTS

SPECTRUM MRI IMAGING CENTER
14365 Pipeline Ave
Chino, CA 91710
PH: 909-591-5587
FX: 909-591-0538

Attorney Name: _____
Address: _____
_____
_____

TO ATTORNEY ON THE CASE OF: _____
DATE OF INJURY: _____

This is a contract and a legal binding document which binds the attorney and patient to insure that the doctor is paid for his services once the case is settled or a verdict is received. PLEASE SIGN AND FAX BACK TO (909) 591-0538.

I do hereby authorize **Spectrum MRI Imaging Center**, to furnish you, my attorney, with a full report of my examination, diagnosis, treatment, prognosis, etc., in regards to the **accident dated** _____.

I hereby authorize and direct you, as my attorney for the personal injury case, to pay directly to **Spectrum MRI Imaging Center** such sums as may be due and owing him/her for medical services rendered me both by reason of this accident and by reason of any other bills that are due his/her office and to withhold such sums from any settlement, or verdict as may be necessary to adequately protect such lien.

This is a third party lien given by the undersigned client to the benefit of the radiology services for the above mentioned case. Your client instructs you not to revise this agreement and sign it immediately. If you fail to sign this document within the specified time, you will be in direct conflict with client instructions.

_____
Patient Initials

I understand that I am directly responsible for the said medicals and for all medical bills incurred for services regardless of the outcome of the case. **I understand, that if the doctor is not successful after due diligence in contacting the attorney or if the attorney refuses to cooperate, that this lien will be void and I am personally responsible for the outstanding medical bills.**

_____ _____
Patient Signature **Date**

_____
Print Name

The undersigned being the attorney for the injured above mentioned party hereby agrees to observe all the terms of this agreement between the doctor and the client and agrees to withhold such sums for any settlement, judgment or verdict as may be necessary to protect said doctor's lien. If dispute arises from this agreement and if the doctor prevails, the attorney or patient, as ordered by court, will be responsible to pay for **actual attorney fees and costs.**

A COPY OR A FAXED COPY OF THIS DOCUMENT IS AS VALID AS THE ORIGINAL

_____ _____
ATTORNEY SIGNATURE **Date**

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PERSONAL INJURY PATIENT INFORMATION FORM

Exam Date: _____/_____/_____ Exam Name: _____

Patient: _____ Date of Birth: _____/_____/_____
First Name Middle Last

Social Security # _____-_____-_____ Driver's License #_____ Gender (circle): Male/Female

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed **Employment Status:** ☐ Employed/Student Part Time ☐ Employed/Student Full Time

Mailing Address: _____
Street Apt# City/State Zip

Home Phone: _____ Cell Phone: _____ Email: _____

Referred By: _____ Emergency Contact: _____ Ph: _____

Please Provide our Office with *all* of the following Incident Information

Attorney/ Law Firm Name: _____ Legal Assistant's Name: _____

Mailing Address: _____

Phone: _____ Fax: _____ Email: _____

Requesting MD: _____ Address: _____

Ph: _____ Fax: _____ Send Additional Reports To: _____

Is this visit related to (circle or ☐) **Auto Accident** **Slip & Fall** **Other (explain):** _____ **Date Of Injury:** _____

Accident Location (circle one): **Store** **Parking Lot** **Other**: _____ Accident Address: _____

Police/Incident Report (circle one): ☐☐ ***Yes/No*** Emergency Room: ☐☐ ***Yes/No*** Ambulance: ☐☐ **Yes/No** **If Slip &Fall:** Approved: **Yes/No** By _____

Please give a brief description of **Accident** and ***how*** injury occurred: _____

_____

_____

_____

Insurance Information

Please provide our office with your Insurance Declaration page

Auto Insurance Name: _____
Policy Number: _____
Address: _____
Adjuster Name: _____ Ph: _____
Claim Number: _____
Policy Limit: _____

Other Party Insurance Information

Auto Insurance Name: _____
Policy Number: _____
Address: _____
Adjuster Name: _____ Ph: _____
Claim Number: _____
Policy Limit: _____

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ASSIGNMENT OF BENEFITS

RELEASE OF MEDICAL RECORDS AND BILLING

I, _____, assign any and all rights and benefits under my policy to the following doctor or facility:

Spectrum MRI Imaging Center 14365 Pipeline Ave. Chino, CA 91710

I ask that any and all checks due to me under my policy to be made out to the doctor or facility mentioned above. If my policy has a prohibition of assignment clause and does not allow assignment of benefits under the policy, then I instruct my insurance company to make the check payable to me but mail the check to the address mentioned above. Any failure to comply with this assignment will be violation of Insurance Code Section 790.03 and Insurance Regulation and will be considered a violation of my rights under the policy.

Authorization to Release Information
I hereby authorize **Spectrum MRI Imaging** to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from **Spectrum MRI Imaging** on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

The payment under the policy should be mailed to my provider at once and no unnecessary delays are acceptable.

POWER OF ATTORNEY:
The above health care provider is hereby given the power of attorney by the undersigned to ***sign my name on any checks*** for payment for services rendered by the above provider._____Initial

I ALSO IMMIDIATELY **RECIND AND VOID ANY AND ALL OTHER ASSIGNMENTS** RECEIVED BY MY INSURANCE COMPANY INCLUDING FROM MY ATTORNEY IN CONNECTION WITH HEALTHCARE SERVICES RECEIVED IN THE OFFICE MENTIONED ABOVE.

_____

SIGNATURE

DATE:

_____
Signature

_____
Print name

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METAL SCREENING FORM

WARNING: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure (i.e., MRI, MR angiography, functional MRI, MR spectroscopy). Do not enter the MR system room or MR environment if you have any question or concern regarding an implant, device, or object. Consult the MRI Technologist or Radiologist BEFORE entering the MR system room The *NM* system magnet is ALWAYS on.

Please indicate if you have any of the following:

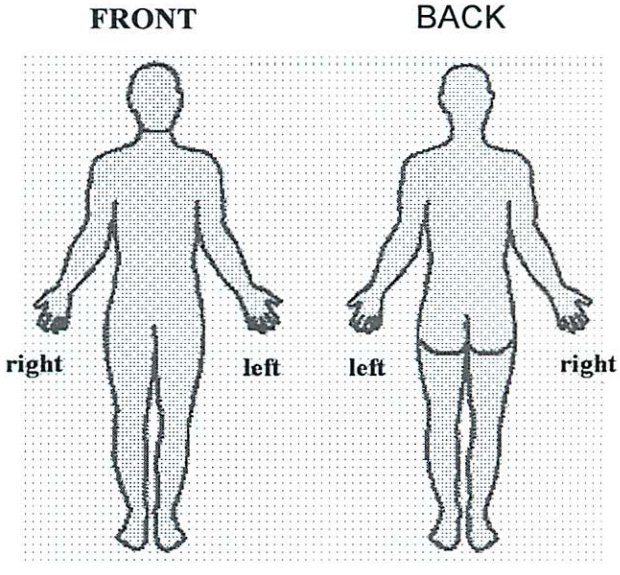
☐ Yes	No	☐ Are you pregnant
Yes	No	Ever had metal removed from eye
Yes	No	Worked with metal fragments, ie. welding, grinding, etc.
Yes	No	Pacemaker
Yes	No	Aneurysmclip(s)
Yes	No	Implanted cardiovertsr defibrillator (ICD)
Yes	No	Electronic implant or device
Yes	No	Magnetically-activated implant or device
Yes	No	Magnet therapy patch
Yes	No	Neurostimulation system
Yes	No	Spinal cord stimulator
Yes	No	Internal electrodes or wires
Yes	No	Bone growth bone fusion stimulator
Yes	No	Cochlear, otologic, or other ear implant
Yes	No	Insulin or other infusion pump
Yes	No	Implanted drug infusion device
Yes	No	Any type of prosthesis (eye, penile, etc.)
Yes	No	Heart valve prosthesis
Yes	No	Eyelid spring or wire
Yes	No	Artificial or prosthetic limb
Yes	No	Metallic stent, filter, or coil
Yes	No	Shunt (spinal or intmventricular)
Yes	No	Vascular access port and/or catheter
Yes	No	Radiation seeds or implants
Yes	No	Swan-Ganz or thermodilution catheter
Yes	No	Foil based medication patch (Nicotine, Nitroglycerine)
Yes	No	Any metallic fragment or foreign body
Yes	No	Wire mesh implant
Yes	No	Tissue expander (e.g., breast)
Yes	No	Surgical staples, clips, or metallic structures
Yes	No	Joint replacement (hip, knee, etc.)
Yes	No	Bone/joint pin, screw, nail, wire, plate, etc.
Yes	No	IUD, diaphragm, or pessary
Yes	No	Dentures or partial plates
Yes	No	Tattoo or permanent makeup
Yes	No	Body piercing jewelry
Yes	No	Hearing aid *(Remove before entering MR system room)*
Yes	No	Other implant _____
Yes	No	Breathing problem or motion disorder
Yes	No	Halo vest or metallic cervical fixation device
Yes	No	Attached weights of any kind (wrist, ankle, or body)

IMPORTANT INSTRUCTIONS

Before entering the *NM* environment or *NM* system, you will be asked to change into a gown and remote your shoes. You must remote all metallic objects including hearing aids, dentures, partial plates, keys, beeper, cell phone, eyeglasses, hairpins, paper-clips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clippers, tools, clothing with metal fasteners, & clothing with metallic threads.

Please consult the *MRI* Technologist or Radiologist if you have any question or concern BEFORE you enter the *MRI* room.

Please mark on the figure(s) below the location of any implant or metal inside of or on your body.



Note: You may be advised or required to wear earplugs or other hearing protection during the *NM* procedure to prevent possible problems or hazards related to acoustic noise.

I attest that the above information is correct to the best of my knowledge. I have read and understand the entire contents of this form and I have had the opportunity to ask questions regarding the information on this form.

Patient's Signature:_____ Date: _____

Front Desk staff signature:_____ Date:_____

Technologist signature: _____ Date:_____

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PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated:** It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician or patient to collect or contest any medical fee shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any malpractice claim, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05; however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:

Effective as of the date of first medical services

_____
Patient's or Patient Representative's Initials

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: _____ _____
Physician's or Authorized Representative's Signature (Date)

_____
Print or Stamp Name of Physician, Medical Group, or Association Name

By: _____ _____
Patient's or Patient Representative's Signature (Date)

By: _____
Print Patient's Name

_____
(If Representative, Print Name and Relationship to Patient)

A signed copy of this document is to be given to the Patient. Original is to be filed in Patient's medical records.

(9-13)