SPECTRUM MRI
FULL BODY IMAGING CENTER

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:_____

Employer/School: _____ Occupation: _____

Address: _____ Phone: _____

Please provide name and address of Guarantor (responsible party) for patient balance

☐ **Same as Patient**

Name: _____ **DOB:**_____ **SSN:** _____

Mailing Address: _____ **Phone:**_____

Requesting MD: _____ Address:_____

PH: _____ Fax:_____ Send Additional Reports To: _____

Please give a brief description for the reason for exam:_____

_____

_____

_____

(If work related, please complete the Worker's Compensation section on next page)

INSURANCE INFORMATION

(Please provide all pertinent information regarding your insurance coverage. If you have secondary insurance please give info for both policies.)

PRIMARY MEDICAL

Insurance Company: _____
Group #_____ Policy #_____
Subscriber Name: _____
Subscriber Address: _____
Subscriber DOB: _____ Gender: _____
Subscriber SSN: _____
Subscriber Employer: _____
Relationship to Subscriber: _____

SECONDARY MEDICAL

Insurance Company: _____
Group #_____ Policy #_____
Subscriber Name: _____
Subscriber Address: _____
Subscriber DOB: _____ Gender: _____
Subscriber SSN: _____
Subscriber Employer: _____
Relationship to Subscriber: _____

Patient Name: _____ MRN#: _____

PRIVACY NOTICE: I acknowledge I have been given the opportunity to read and receive a copy of the Spectrum MRI Notice of Privacy Practices that explains tome how Spectrum MRI will use and disclose my information. I understand that Spectrum MRI does not need my permission to disclose health information for purposes related to treatment, payment, or routine business operations.

RELEASE OF MEDICAL RECORDS: By signing this form, I hereby authorize release of my medical records, inclusive of all test results and pertinent information acquired during my treatment, to/from other physicians and healthcare providers. In addition, I understand that I have the right to request a copy of my medical record, or a portion thereof, at anytime, and that Spectrum MRI will do its best to respond to my request at the time of the request or as reasonably soon thereafter. I acknowledge and understand that I may incur fees associated with the copying of such medical records.

In addition, by signing below, I hereby authorize the release and disclosure of my medical information to the following individuals:

_____ _____

(Name) (Relationship) (Name) (Relationship)

This authorization extends to all of my protected health information that is disclosed for general information purposes and is valid until revoked. The information that maybe disclosed includes but is not limited to: statements of charges or payments, records of visits for any and all dates, copies of records or reports provided to other physicians and providers, history and physical examination reports, and consultation reports. I understand that I may revoke this authorization at anytime, except where information has already been released. The revocation must be in writing and sent to Attention: Privacy Officer, Spectrum MRI 14365 Pipeline Ave. Chino, CA 91710. Spectrum MRI, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. I further understand that information used or disclosed pursuant to this authorization maybe subject to re-disclosure by the recipient and is no longer protected.

ASSIGNMENT OF BENEFITS: I hereby authorize payment of all health insurance benefits to Spectrum MRI and allow Spectrum MRI to release all information necessary to secure payment. I agree that a photocopy of this authorization shall be considered as effective and valid as the original. I understand that I am legally responsible for all charges incurred whether or not they are paid by my health insurance, and that any unpaid balance shall be due in full IMMEDIATELY if insurance proceeds are paid directly to me.

HIV TESTING AFTER ACCIDENTAL EXPOSURE: I understand that in the event a healthcare worker is exposed to my blood or body fluids during my exam/procedure, my blood maybe tested for HIV antibody and other communicable disease at no cost to me.

CONSENT TO CONTACT: I acknowledge and agree that Spectrum MRI can contact meat any of the phone numbers listed on page one of this form for any purpose related to services I receive at .

TREATMENT CONSENT: I am consenting to the provision of any medically-necessary tests or procedures to be performed on this date.

SIGNATURE: _____ DATE: _____

(Patient/ Parent/ Legal Guardian)

PRINTED NAME: _____ TELEPHONE NUMBER: _____

This section to be completed for Worker's Compensation Claims Only

Employer (At time of Injury) _____ Date of Injury: _____

Employer Contact Person: _____ Employer Contact Phone: _____

Briefly Describe the Original Cause of Injury: _____

_____

Name of Workers Compensation Insurance Company: _____ Phone: _____

Mailing Address: _____

Street _____ Apt# _____ City/State _____ Zip _____

Claim # _____ Claim Adjuster Name: _____ Claim Adjuster Ph: _____

Have you previously had this procedure performed for this injury? Yes o No o

I understand that businesses in the state of Texas have the option of providing Worker's Compensation insurance or an accident policy. By Law, Worker's Compensation insurance requires Spectrum MRI to file your claim. It is not required by law that the provider of service file this claim if your employer has an accident policy. However, we do provide this service as a courtesy to our patients. Patients filing under an accident policy may be responsible for payment.

_____ _____

Signature Date

SPECTRUM MRI
FULL BODY IMAGING CENTER

HIPAA Notice of Privacy Practices

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

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law .

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information maybe provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.
You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.
Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

Your Rights

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Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and became effective on/or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

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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:

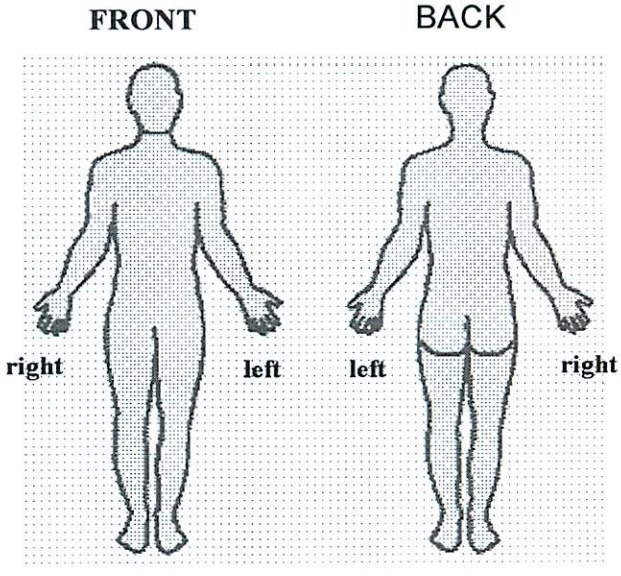
Yes	No	Are you pregnant
Yes	No	Ever had metal removed from eye
Yes	No	Worked with metal fragments, ie. welding, grinding, etc.
Yes	No	Pacemaker
Yes	No	Aneurysmclip(s)
Yes	No	Implanted cardiovertsr defibrillator (ICD)
Yes	No	Electronic implant or device
Yes	No	Magnetically-activated implant or device
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:_____

14365 Pipeline Ave. Chino, CA. 91710 • (909) 591-5587 • Fax: (909) 591-0538

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)