Open MRI of Camden

Patient Information

Name : _____ SSN: _____-_____-_____
Last First Middle Int.

Mailing Address:_____ Apt #: _____

City: _____ State: _____ Zip Code: _____-_____

Preferred Contact Phone: (_____) _____ Text or Voicemail
(Circle One)

Email Address: _____

Date of Birth _____/_____/_____ Age: _____ Marital Status: S M D W Sex: M F
(Circle One) (Circle One)

Race/Ethnicity: African American/Asian/ Caucasian/Hispanic/Latino-Hispanic/Native American/Other
(Circle One)

Referring Physician:_____ Phone: (_____)_____

Employer: _____ Phone: (_____) _____

Emergency Contact:

Name: _____ Phone: (_____) _____ Relationship_____

Insurance Guarantor:

Name: _____ Relationship: _____

SSN: _____-_____-_____ Date of Birth: ___/____/____ Phone: (_____) _____

Address: _____

Primary Insurance:

Insurance Name: _____ Relationship to Patient: _____

Policy # _____ Group #_____ Policy Holder's SSN _____-_____-_____

Secondary Insurance:

Insurance Name: _____ Relationship to Patient: _____

Policy # _____ Group #_____ Policy Holder's SSN _____-_____- _____

Assignment of Benefits and Authorization for Treatment

Acknowledgement of Receipt of Notice of Privacy Practices: I hereby certify that I have received a copy of the Notice of Privacy Practices for Open MRI of Camden. I also acknowledge that Open MRI of Camden reserves the right to revise the notice and that any future changes or revisions will apply to all protected health information contained in my medical records for Open MRI of Camden. **Initial:** _____

Consent for Medical and Surgical Treatment: I authorize Open MRI of Camden to furnish the necessary medical or surgical treatments, or procedures, including diagnostic x-ray, laboratory procedures, contrast injection, and/or drugs. I also authorize the attending physician(s), his assistants, or his designees to order supplies as needed. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as to the results of treatment/diagnostic procedures in Open MRI of Camden. I recognize that the physician(s) who practice at Open MRI of Camden are not employees of Open MRI of Camden but are independent physicians. Open MRI of Camden may delegate to these independent physicians those services physicians normally provide; any questions relating to care which physician has given or ordered should be directed to him/her. **Initial:** _____

Authorization for Release of Information and Medical Records: I hereby authorize Open MRI of Camden to release any information regarding diagnosis and treatment requested by referring physician(s) or attorney (if applicable). I also authorize release of same to insurance company to collect benefits under the policies. I further authorize any physician or institution that attended to this patient previously to furnish medical records and/or information which may be requested by Open MRI of Camden or attending physician. **Initial:** _____

Assignment of Benefits: I hereby authorize payment directly to Open MRI of Camden of any and all medical benefits applicable and otherwise payable to me. I hereby irrevocably assign to Open MRI of Camden the rights & benefits under any policy of insurance, indemnity agreement, or any other collateral source as defined in Georgia Statures for any services and/or charges provided by Open MRI of Camden. I understand that I am financially responsible to Open MRI of Camden for charges not covered by this assignment. **Initial:** _____

THIS AUTHORIZATION MUST BE SIGNED IN ORDER TO EXPEDITE SERVICES TO BE RENDERED AS WELL AS THE FILING OF YOUR INSURANCE CLAIM, IF APPLICABLE.

_____ Patient unable to sign due to _____

Print Patient Name

_____ _____ _____

PATIENT/GUARDIAN *SIGNATURE* **Date** Employee Initials

**** IF APPLICABLE ** INITIAL FOR AUTO OR WORK COMP.****

****Auto Accident Liability/Insurance Waiver:** I hereby state that I wish Open MRI of Camden to submit my claim for services rendered to my insurance company for services rendered for the *accident date of* _____. *State where accident occurred*: _____. I am not filing this claim with any other liability insurance and will not be making any payment to any other general liability insurance that will have to be refunded immediately. I understand that the total amount originally charged for the services rendered will become due and payable by me. Filing your liability insurance does not constitute an assignment. **If this is a legal case, we do not accept assignment pending the outcome of your case. You are responsible for your bill in its entirety.** **Initial:** _____

****Worker's Compensation:** This authorizes my physician to furnish written reports and communicate orally with any representative, attorney for, or investigation from, my worker's compensation carrier regarding my examination, diagnosis, treatment and prognosis concerning injuries sustained as a result of an accident occurring on _____. **Initial:** _____

Attorney: (Name)_____ **Address:** _____

Phone # _____ **Fax #** _____

Open MRI of Camden

Your doctor has referred you for a CT. Please answer the questions below.

Date: _____

Patient's Name: _____ Date of Birth: _____

Reason for chest CT. _____

Do you currently have chest pain? Yes No

Do you currently have a cough? Yes No

Are you currently coughing up blood? Yes No

Do you have high blood pressure? Yes No

Do you have heart disease? Yes No
If yes what type? _____

Have you had an injury to your chest? Yes No
If yes, please describe and when_____

Do you have cancer? Yes No
If yes, what type? _____
Where? _____

Do you or are you having trouble breathing? Yes No

Are you or have you ever been a smoker? Yes No
If you have quit, When? _____

Do you have pneumonia or any lung disease? Yes No
If yes, what type? _____

Have you been diagnosed with any of the following?

Emphysema	Yes	No
Bronchitis	Yes	No
Asthma	Yes	No

Patient's Signature: _____

PATIENT DISCLOSURE AND INFORMED CONSENT – CT

Patient Name_____ MR#_____

Your doctor has requested that you have a Computed Tomography (CT) examination to aid in your medical diagnosis. CT is a medical imaging procedure, which utilizes x-rays and sophisticated electronic equipment to visualize the internal body structures.

PLEASE READ AND CIRCLE YES OR NO TO THE FOLLOWING QUESTIONS:

Are you wearing a wig or hairpiece?	Yes	No	Heart disease?	Yes	No
Are you wearing dentures or partial?	Yes	No	Congestive heart failure?	Yes	No
Are you wearing a hearing aid?	Yes	No	Irregular heartbeat?	Yes	No
Are you wearing an ostomy appliance?	Yes	No	Kidney disease?	Yes	No
Are you wearing an artificial eye or limb?	Yes	No	Kidney stones?	Yes	No
Are you wearing a neurostimulator?	Yes	No	Cancer?	Yes	No
Allergies to medications?	Yes	No	Diabetes?	Yes	No
Do you have any allergies to shellfish or Iodine?	Yes	No	If Yes, taking Glucophage?	Yes	No
Have you ever had radiation therapy?	Yes	No	High blood pressure?	Yes	No
Have you ever had chemotherapy?	Yes	No	Glaucoma?	Yes	No
Are you pregnant?	Yes	No	Sickle cell anemia?	Yes	No
Are you nursing an infant?	Yes	No	Severe dehydration?	Yes	No
Have you ever had a contrast injection with any adverse effect?	Yes	No	Asthma?	Yes	No
Do you have seizures?	Yes	No	Lung disease?	Yes	No
			Eczema?	Yes	No
Any other medical problems?	Yes	No			

If Yes, describe: _____

_____

I understand that the procedure to be performed on me involves the use of x-rays, and possibly injection needles and iodine containing solutions (x-ray dye), which may enhance the diagnostic accuracy of the procedure.

You may be receiving an intravenous contrast media and/or oral contrast media to enhance the visibility of certain tissues. Possible side effects may include, but are not limited to, pain or swelling at the site of injection, nausea, vomiting, a warm flushed feeling, potential allergic reaction including, but not limited to hives, wheezing, difficulty breathing, and in rare instances, anaphylactic shock (severe allergic reaction). More severe reactions may occur, including death. However, should a reaction occur, there are trained medical staff (including a physician) and medications available to treat the reaction. The purpose, benefits and complications of the contrast procedure will be explained to your satisfaction before any injection takes place.

I hereby consent to any measure necessary to correct complications, which may occur. I am aware that the practice of medicine is not exact science and I acknowledge that no guarantees have been made to me concerning the results of this examination.

I confirm that the information I provided is complete and accurate to the best of my knowledge. I have read, understand, and hereby consent to this CT examination.

Patient Signature
Parent or Guardian if Patient is a Minor

Date

Witness

Date

Disclosure of Protected Health Information

By law, medical information is confidential unless written authorization is given. This form is designed for you, the patient, to specify exactly whom you **do** and **do not** want to receive medical information pertaining to your care at our facility.

Therefore, I _____ authorize OPEN MRI OF CAMDEN to give medical information to the following persons:
***The information requested is for personal family and/or friends, NOT the referring physician.**

Name	Relationship
_____	_____
_____	_____
_____	_____

OR

I request that you **DO NOT** disclose medical information to anyone other than myself. _____
I prefer that my medical information should **NOT** be released to the following person(s):

_____, _____, _____
***Please note, unless otherwise specified, the referring physician is authorized to receive a copy of your report.**

☐ Do / ☐ Do not leave messages on answering machine or voicemail.

☐ Do / ☐ Do not call me at home.
If not, please provide alternate telephone contact info:
_____

☐ Do / ☐ Do not call me at work.

☐ Do / ☐ Do not mail statements or other correspondence to my home. If not, please Provide alternate mailing address:
_____
_____
_____

This remains in effect until I give written notification to discontinue or change.

_____ _____
Patient Signature **Date**

Parent/Guardian of minors under age 18 has access to medical records, except for any State Law protecting the privacy of information of minors.