GO IMAGING -CENTRAL

PATIENT INFORMATION / FINANCIAL RESPONSIBILITY

Name: _____ SSN: _____
Last First Middle Initial

Date of Birth: _____ Sex*: _____ Marital Status (please circle): S / M / W / D

Home Phone: (_____)_____ Daytime: (_____)_____ Cell: (_____)_____

Address: _____
Street Address (no PO boxes) City State Zip

_____
Mailing Address City State Zip

Email address: _____
(Your email will not be sold or given to any third parties. It will only be used internally.)

Employer: _____ Employment Status (circle): FT / PT / Retired / Not Employed
Company Name

Emergency Contact: _____
Name Relationship Phone

How did you hear about us? (check): ☐ Physician Referral ☐ Returning Patient ☐ Internet ☐ Word of Mouth ☐ Other

Were you injured? Y/N **Is this injury work related? Y/N** Are you filing a workers compensation claim? Y/ N

Do you reside in a Skilled Nursing Facility? Y/N Name & Phone of SNF:_____

INSURANCE - Check all insurances you have: ☐Medicare ☐Medicaid ☐PPO ☐HMO ☐LOP ☐Work Comp ☐Other

Primary Insurance: _____ Policy Holder:_____
Last First MI

SSN of Policy Holder: _____ Policy Holder's DOB: _____

Policy ID Number: _____ Group Number: _____

Patient's Relationship to Policy Holder (please check): ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Policy Holder's Employer: _____ Work Phone: _____

If you do not have a secondary insurance, please write "none."

Secondary Insurance: _____ Policy Holder:_____
Last First MI

SSN of Policy Holder: _____ Policy Holder's DOB: _____

Policy ID Number: _____ Group Number: _____

Patient's Relationship to Policy Holder (please check): ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Policy Holder's Employer: _____ Work Phone: _____

Which method of payment will be used for today's visit? ☐ Visa ☐ Mastercard ☐ AMEX ☐ Cash ☐ Check

For Patients under 18, the Parent/Guardian accompanying minor must provide the information below and sign as the guarantor.

Guarantor: _____ SSN: _____

DOB: _____ Phone: _____ Relationship to Patient: _____

Address: _____

I hereby certify that the above information is true and accurate to the best of my knowledge and Oakridge Imaging LLC, an affiliate of Green Oak Diagnostics, may rely on this information to provide these services. I assign and authorize that payment of these medical benefits be made directly to *GO Imaging - Central.* I further authorize *GO Imaging - Central* to release to my insurance carrier information pertaining to my examination and treatment. I understand that I am financially responsible for any charges not covered by my insurance carrier and a $25 fee per returned check cost of collection, if necessary. I understand if payment is not made by my insurance company and/or if I fail to comply with my payment arrangements, my credit report information may be obtained. By listing the information above, I am allowing *GO Imaging - Central* to contact me via any of the methods I have provided.

Signature of Responsible Party: _____ **Date:** _____

GO IMAGING - CENTRAL

Authorization for Use or Disclosure of Information

I, _____, hereby authorize ***Oakridge Imaging LLC, an affiliate of Green Oak Diagnostics*** (hereafter ***GO Imaging Central***) to:

(*Please check one or both of the following:)*

_____ use and disclose the following protected health information to any physician that can reasonably identify me by name, date of birth and social security number and, and/or

_____ use and disclose the following protected health information to:

(Please indicate below to whom we may release information. Please include the names of family members and/or friends.)

_____

(*Please check off what type of information you would allow us to release.*)

_____all medical records _____all billing records

This protected health information is being used or disclosed for the following purpose: To diagnose and/or treat the patient and/or: [List specific purposes here:]_____.

This authorization shall be in force and effect **indefinitely**; I understand that an expiration date may be applied at the time of service and/or that I have the right to revoke this authorization, in writing, at any time by sending such written notification to **Jason Bandoo** at **jbandoo@go-imaging.com**. I understand that a revocation is not effective to the extent that ***GO Imaging Central*** has relied on the use or disclosure of the protected health information. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. ***GO Imaging Central*** will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to:

- Inspect or copy 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.)
- Refuse to sign this authorization.

[The use or disclosure requested under this authorization will result in direct or indirect remuneration to ***GO Imaging Central*** from a third party.] [if applicable.]

_____ _____

Signature of Patient or Personal Representative | Name of Patient or Personal Representative

_____ _____

Date | Description of Personal Representative's Authority

Consent for Purposes of Testing, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by ***Oakridge Imaging LLC, an affiliate of Green Oak Diagnostics*** (hereafter ***GO Imaging Central***) for the purpose of providing services to me, obtaining payment for my health care bills or to conduct health care operations of ***GO Imaging Central***. I understand that service provided to me by ***GO Imaging Central*** may be conditioned upon my consent as evidence by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out services, payment or healthcare operations of the facility. ***GO Imaging Central*** is not required to agree to the restrictions that I may request. However, if ***GO Imaging Central*** agrees to a restriction that I request, the restriction is binding on ***GO Imaging Central***. I have the right to revoke this consent, in writing, at any time, except to the extent that ***GO Imaging Central*** has taken action in reliance on this consent.

I understand I have a right to review ***GO Imaging Central*** Notice of Privacy Practices prior to signing this document and that it is available upon request. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my test, the payment of my bills or in the performance of health care operations. ***GO Imaging Central*** reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail.

As a courtesy, our facility will file your claim to your insurance company. However, since there is no guarantee of payment by an insurance company, you will be responsible for payment for services received in our office should the insurance not pay plus the cost of collection, if needed. Should collection proceeding or other legal action become necessary to collect an overdue account, the patient or the patient's Responsible Party, understands that ***GO Imaging Central*** has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect payment for services rendered. The patient, or the patient's Responsible Party, understands that they are responsible for all costs of collection.

_____ _____

Signature of Patient or Personal Representative | Name of Patient or Personal Representative

_____ _____

Date | Description of Personal Representative's Authority

GO IMAGING

MRI – TECH SHEET

Patient Name: _____ Date: _____
Last First MI

D.O.B.:_____ Age: _____ Sex: _____M _____F Weight: _____ Ht: _____

Were you injured?_____Yes _____No If yes, when & how?_____

DESCRIBE YOUR SYMPTOMS: (Area of complaint, how long you have had symptoms, any prior treatment, etc.)**:**

_____

_____

Have you had a previous exam related to this body part? _____Yes _____No

If yes, when, where, and results:_____

Do you or have you smoked? _____Yes _____No

If yes, how much and for how long?_____

List all previous **SURGERIES:**_____

_____

List other **MEDICAL PROBLEMS**:_____

_____

ANY PERSONAL HISTORY OF:

Yes	No		Yes	No	
		Asthma / Allergic Respiratory Disease			Dizziness / Vertigo
		Diabetes			Headaches
		Multiple Myeloma			Stroke
		Prostate Enlargement OR Cancer (Please circle)			Seizure Disorder
		Organ Transplant, if yes Organ:_____			Liver Disease
		Chronic kidney disease or Renal Failure			Heart Disease
		Painful urination or blood in urine			Hypertension (High Blood Pressure)
		Cancer. If yes, Type: _____ Date of Diagnosis: _____ Prior Treatment:_____			Under care of Specialist? Type of Specialist: _____

If you are on **DIALYSIS**: When did you begin dialysis? _____How often? _____Next date: _____

If you are still producing urine, please state how much: _____

In the past 24 hours have you had an IV Contrast injection?_____Yes _____No

List all medications presently taking: _____

List all drug allergies: _____

When did you last eat anything? _____

FEMALE PATIENTS:

Any possibility of pregnancy? _____Yes _____No Last Menstrual Period: _____
Number of pregnancies: _____ Number of Live Births: _____

_____ _____
Patient Signature Date

(***If patient is under 18 years of age, guardian must sign***)

Yes	No	
		Cardiac Pacemaker
		Brain Surgery/Aneurysm Clips Date:
		Carotid Artery Clips Date:
		Vascular Clamps Date:
		Neurostimulators (TENS)
		Heart Valve
		Electrodes
		Hearing Aid
		I.U.D. Type:
		Shunt: Spinal or Ventricular
		Fractured bones or spine treated with:
		Metal Rod Date:
		Metal Plates Date:
		Metal Pins Date :
		Screws Date :
		Tattoos (Homemade)
		Kidney disease
		Permanent Makeup
		Sickle Cell Anemia

Yes	No	
		Intravascular coil: filter
		Thermodilution Swan - Ganz catheter
		Wire Sutures: Location: Date:
		Chemotherapy Pump
		Dental work: (Bridges, Dentures, etc.)
		Metal Fragments of BB shot Location:
		Prosthesis of :
		Joint Location :
		Extremities Location:
		Eye L / R (please circle)
		Middle Ear/ Cochlear Implant: (please circle) L / R
		Electronic Monitoring Device
		Medication Pump Type:
		Joint Replacement Location:
		Shrapnel / gunshot wound Location:
		Hepatitis
		Stents
		Other Metal Implants (please specify):
		Have you ever had or do you have metal fragments in your eyes?

The patient should not enter the scan room with any of the following items:

-Glasses	-Wallet/money clip	-Jewelry/ Earrings	-Pens/ Pencils	-Shoes
-Hearing aid	-Keys/ coins	-Pocket knife	-Watch	-Metal zippers
-Removable dental work	-Belt buckle	-Metal bra hooks	-Hairpins	

CONSENT FOR INTRAVENOUS CONTRAST INJECTION

The MRI examination your doctor has ordered requires that an injectable contrast agent, Gadolinium, be administered. Gadolinium will be administered to you by intravenous injection, (in vein). This contrast is eliminated through the urinary system within 24 hours after injection. Primary use of this agent is to provide contrast enhancement of the study to make it easier to see areas of concern or interest, such as blood vessels and scar tissue. The introduction of contrast into the body can cause a mild to severe reaction, but this rarely occurs. Please answer the following questions and sign.

CONSENT FOR AIDS/ HIV TESTING IN CASES OF ACCIDENTAL EXPOSURE

I understand that if a healthcare worker is accidentally exposed to my blood or bodily fluids in such a fashion that the worker may be at risk for contracting Viral Hepatitis, and/ or AIDS, I will be required to have my blood tested. This is pursuant to Texas law and Hospital protocols to determine the presence of Hepatitis, Surface Antigen and/or Human Immunodeficiency Virus (HIV). Test results will be kept confidential to the extent allowed by law and any information concerning my identity in connection with such testing will be destroyed after testing and notification of the healthcare worker who was exposed.

This procedure has been explained to me, and I give my consent for the intravenous injection of Gadolinium and for HIV/ AIDS testing in the case of accidental exposure. I understand that as with any medication, there is a risk for minor or adverse reactions. I have asked questions received answers concerning areas I did not understand, and I understand what I have read and have been given.

PRINT NAME:_____ DATE: _____

SIGNATURE:_____ WITNESS: _____

OFFICE USE ONLY

Appointment Time: _____

Table Time: _____

Tech made patient aware of table time: YES NO

Tech Notified Manager: YES NO