NAME _____

COL _____

DATE _____/_____/_____

TIME _____

PT appt confirmed Y N L/M _____

PT knows about $ Y N L/M _____

Amount Due Now _____

Amount Due Later _____

1.2 ☐

3.0 ☐

Patient Information Form

Last Name: _____ First Name: _____ MI: _____

Address: _____

City: _____ State: _____ Zip Code: _____

DOB: _____/_____/_____ SS#: _____

Phone: _____ Email: _____@_____

Status: **Single/Married** Sex: **Male/Female** Employer: _____

Emergency Contact Information: (Name) _____(Phone)_____

Minor Consent:

Guardian Name: _____ Guardian D.O.B: _____/_____/_____

Guardian Signature: _____

Insurance Information:

Primary: _____ **Secondary**: _____

If Work Related Injury (*Please Complete for all Workers Compensation Claims*)

Date of Injury: _____/_____/_____ Cause of Injury: _____

Employer at Time of Injury: _____ Claim #: _____

If Motor Vehicle Related Injury

Date of Injury: _____/_____/_____ Claim #: _____

Motor Vehicle Insurance: _____

Patients please read and sign below

Benefit Agreement: I request that payment of authorized Benefits Coordination be made on my behalf to Coliseum Imaging for any services furnished me. I authorize any holder of medical information about me to release to the health care financing administration or my insurance company/agents any information needed to determine benefits payable for related services. A copy of this signature is as valid as the original. As a courtesy to you, we can file a claim to your insurance carrier/payor/attorney. Insurance providers/Payors may deem this test medically unnecessary and there is no guarantee of benefits. By signing this form, I understand that I am financially responsible for any and all remaining balances.

→ **Authorized Signature _____ Date_____/_____/_____**

Please help us by following up with your insurance company for any unpaid claims

Notice of Intent to Protect Privacy (HIPAA)

The department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. This rule requires providers to obtain patient consent to use their healthcare information for treatment, payment or other healthcare operations. As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We also want you to know that we support your full access to your personal medical records. You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Protected Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent. You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

I hereby authorize the release of all or any portion of my medical records to any health care practitioner or facility designated by me.

→ **Authorized Signature _____ Date_____/_____/_____**

Name of person, if any, that you give permission to have access to your medical/billing records.

Name: _____ Relationship: _____

Patient Feedback Consent

Coliseum Imaging Center is committed to providing the best possible patient experience and values your feedback. By signing below you hereby authorize Coliseum Imaging Center to send you a one-time text message to rate your experience and provide an opportunity to share feedback.

→ **Authorized Signature _____ Date_____/_____/_____**

COLISEUM Imaging Center

1.2 ☐

3.0 ☐

MRI SCREENING FORM

Patient Information

Name _____ Date _____/_____/_____ Chart _____

DOB _____/_____/_____ Age _____ Weight _____

Reason for MRI and/or symptoms _____

_____

_____

How long have you had these symptoms? _____

Are symptoms a result of a motor vehicle accident? YES _____ NO _____

IF YES Date of accident: _____/_____/_____ State accident occurred: _____

Medical Information

Please list any surgical history by body part: _____

_____

_____

Have you had a prior medical imaging study or exam (MRI, CT, X-Ray, etc.) on the body part we are looking at today? YES _____ NO _____

IF YES, please list: _____

Are medication allergies? YES _____ NO _____ IF YES, please list _____

Chance of pregnancy? YES _____ NO _____ Currently breastfeeding? YES _____ NO _____

Any cancer history? YES _____ NO _____ IF YES, please list _____

Is there any chance of metal fragments (metallic slivers, shavings, foreign body, etc.) in your eyes from welding, grinding or from an injury? YES _____ NO _____

IF YES, has all metal been removed by a physician? YES _____ NO _____

Are you or have you been in contact with someone experiencing any clinical symptoms consistent with Coronavirus including fever, respiratory illness, including persistent coughing, shortness of breath or other flu-like symptoms? YES _____ NO _____

OVER →

MRI SCREENING FORM

Please answer the following safety questions – do any of the following apply? Circle YES or NO

YES NO Cardiac Pacemaker or Pacemaker

YES NO Wires Implanted Cardioverter

YES NO Neurostimulator

YES NO Bone Growth Stimulator

YES NO Insulin or other Infusion Pump

YES NO Cochlear Ear Implants

YES NO Arterial Clips

YES NO Stent, Filter or Coil in blood vessels

YES NO Artificial or Prosthetic joint or limb

YES NO Body Piercing Jewelry

YES NO Colonoscopy within the past year

YES NO Glucose Monitor

YES NO Aneurysm Clip(s)

YES NO Electronic Implant or Device

YES NO Spinal Cord Stimulator

YES NO Internal Electrodes or Wires

YES NO Eye Implants

YES NO Penile Implant

YES NO Metal Implants

YES NO Transdermal medication patch

YES NO Removable Dentures

YES NO Birth Control Implant

YES NO Hearing Aids

Please list any additional information you feel is pertinent to today's exam _____

_____

_____

_____

Patient Signature _____ Date: _____/_____/_____

MRI Technologist Signature _____

Before entering the MRI scan room you must remove certain items from your person including:

Hearing aids, cell phone, hair pins, jewelry, watch, magnetic strip cards

Coliseum Imaging provides lockers and the MRI Technologist will direct you to one prior to your exam.