ONSITE RADIOLOGIST

REGISTRATION FORM

Date:	Referring Physician/ Clinic:

PATIENT INFORMATION

Patient's Name:		SSN:	DOB:	Sex:
Street address:		City:	State:	
ZIP Code:	Cell Phone:	Home Phone:		
Occupation:	Employer:		Employer phone no.: ( )	
Referred By:				

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	DOB:	Address (if different):	Home phone no.: ( )
Is this person a patient here? ❑ Yes ❑ No			
Occupation:	Employer:	Employer address:	Employer phone no.: ( )
Is this patient covered by insurance? ❑ Yes ❑ No ❑ Self-Pay			
Primary insurance Company:		Subscriber's Name:	

Subscriber's S.S. no.:	DOB:	Group no.:	Policy no.:	Co-pay:$
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other				

Name of secondary insurance (if applicable):	Subscriber's name:	Group no:	Policy no:
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other			

ATTORNEY INFORMATION

Name:	Phone:
Type of Accident:	Date of Accident:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Cell phone no.: ( )	Home phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the Onsite Radiologist. I understand that I am financially responsible for any balance. I also authorize RADIOLOGIST or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

Patient History and MRI Safety Screening

Patient's Name:_____ Date:_____

DOB:_____ Weight:_____

⚠ **Please remove all metal objects from your body and clothes before entering CT and or MRI area. Ex: Earrings, keys, hair clips, bobby pins, safety pins, watch, jewelry, etc.). This information was given orally to the patient at this time of this procedure.**

⚠ **ATTENTION: MRI Patients and Accompanying Family Members: The MR room contains a very strong magnet. Before you are allowed to enter, we must know if you have metal in your body. Some metal objects can interfere with your scan or even be dangerous, so please answer the following questions carefully.**

DO YOU HAVE ANY OF THESE ITEMS IN YOUR BODY?

☐ **YES**	☐ **NO**	**Pacemaker, Pacemaker Wires, or Defibrillator**
☐ **Yes**	☐ **No**	**Brain/aneurysm clip**
☐ **Yes**	☐ **No**	**Neuro/electrical stimulator**

⚠ **If you said YES to any of above, you CANNOT have a MRI**

☐ Yes	☐ No	Ear Implant	☐ Yes	☐ No	Eye Implant
☐ Yes	☐ No	Eyelid Tattoo	☐ Yes	☐ No	Infusion Pump
☐ Yes	☐ No	Bullets, BBs or Pellets	☐ Yes	☐ No	Artificial Limb or Joint
☐ Yes	☐ No	Metal Shrapnel or fragments	☐ Yes	☐ No	Magnetic Implant anywhere
☐ Yes	☐ No	Artificial heart valve	☐ Yes	☐ No	Shunt
☐ Yes	☐ No	Diaphragm or intrauterine device	☐ Yes	☐ No	Coil, filter or wire in blood vessel
☐ Yes	☐ No	Implanted catheter, tube, or stent	☐ Yes	☐ No	False teeth, retainers or braces
☐ Yes	☐ No	Surgical clips, staples, wires, mesh or structures	☐ Yes	☐ No	Orthopedic hardware (Plates, screws, pins, rods, wires)

I hereby certify that I have read and understood the questions asked in this questionnaire and that the above responses are correct to the best of my knowledge. I understand that it is my responsibility to inform Onsite Radiologist employees of any metal fragments and/or devices that may be in my body and that by failing to do so may cause serious bodily injury or be life threatening. I agree that should I have any metal in by body, and after consultation with a physician, elect to proceed with the MRI procedure I agree to release Onsite Radiologist from all liability for any injury.

Patient/Guardian signature *Date*

***Please discourage the patient from wearing eyeliner, eye shadow, lotions and body powder that may contain metallic flakes. These products may cause minor burns to the body during the MRI procedure**

ONSITE RADIOLOGIST

NOTICE OF PRIVACY PRACTICES

PATIENT ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I was provided with a copy of Onsite Radiologist Notice of Privacy Practices. I understand that if any changes are made to this Notice of Privacy Practices, a revised copy of the Notice will be posted in the offices of ONSITE RADIOLOGIST. I also understand that if I wish to receive additional copies of this Notice of Privacy Practices in the future or if I have any Questions with regard to this Notice of Privacy Practices, I may contact Privacy Officer at Onsite Radiologist 3547 Peachtree Industrial Blvd. Duluth GA 30097.Phone: 770-299-1332 / 770-299-1344, Fax: 770-741-0097.

⚠ **INSURANCE DISCLAIMER: Verification of the Patient's Health Insurance coverage is the Patient's Responsibility. As a courtesy, 'ONSITE RADIOOGIST' has contacted your insurance company to obtain benefit verification for your procedure today. Each Verification received from the insurance company comes with a disclaimer: "Benefits received are only an estimate and is not a guarantee of payment. Benefits are based on the terms, conditions, exclusions and eligibility of each plan. All benefits are subject to review upon submission of claim". Onsite Radiologist has contacted your insurance Company and determined benefits and estimated deposit for your procedure. I understand that any deposit paid today is not a guarantee of final payment and that it is only an estimate based on the information received from the insurance company and the contracted rate with our facility.**

Onsite Radiologist provides one CD disc to patient containing the scan images free of charge. Any additional CD disc are charged at $25/ disc.

Signature _____ Date _____

PRINT NAME _____

If completed by a Patient's personal representative, please print and sign your name in the space below

Personal Representative Signature _____ Date _____

Relationship _____

IN CASE OF EMERGENCY		
Name:	Relationship:	Phone:

For ONSITE RADIOLOGIST Use Only

Complete this section if this form is not signed and dated by the patient or patient's personal representative.

I have made a good faith effort to obtain a written acknowledgement of receipt of Onsite Radiologist Notice of Privacy Practices but was unable to for the following reason

- ☐ Patient refused to sign
- ☐ Patient unable to sign
- ☐ Other: _____

Employee Name _____ Date _____

PREGNANCY CONSENT FORM

INFORMED CONSENT TO PROCEED WITH MRI PROCEDURE DURING PREGNANCY

This consent is to inform you the Magnetic Resonance Imaging (MRI) procedure you are having today is at a possible risk to your unborn child/fetus. By signing this you are consenting to understanding all of the information below and have asked all questions needed to understanding the risks associated with the procedure.

To date, there are no reports of injury to children who underwent MR imaging before birth. While the number of patients scanned during pregnancy is small, with limited follow-up, in the past several years, numerous pregnant patients have undergone MRI with no ill effects. MR imaging of pregnant patients is carried out when the patient's physician has decided that the advantages of MRI outweigh the potential risks.

I have read the above warning and understand the potential harmful effects to my unborn fetus. I consent to have this MRI procedure as prescribed by my physician. I acknowledge that I have been given ample opportunity to ask questions and that all questions have been answered to my satisfaction. Furthermore, I fully understand that I may refuse to have this MRI procedure conducted on me without any obligation to Onsite Radiologist, llc. or any of its subsidiaries. Also, I understand that I may stop this MRI procedure at any time during its process.

Furthermore, I fully agree that the risks described herein are risks that I am willing to accept. Also, I agree that I will hold harmless Onsite Radiologist, llc and any of its subsidiaries, owners, and employees should I, or my fetus, experience any negative effects from this MRI procedure.

_____ _____

Signature Date

_____

Printed Name of Person giving consent:

_____ _____

Signature of the Witness giving consent Relationship

_____ _____

Technologist Date