PATIENT REGISTRATION FORM

PATIENT INFORMATION			
PATIENT NAME (Last, First, MI)	DATE OF BIRTH	SOCIAL SECURITY NUMBER	GENDER *M / F*
ADDRESS	CITY, STATE, ZIP		
HOME PHONE	DAY PHONE	EMAIL ADDRESS	
MARITAL STATUS	EMERGENCY CONTACT NAME	EMERGENCY RELATIONSHIP	EMERGENCY CONTACT PHONE NUMBER

Notice of Privacy Practices Acknowledgement: I understand that, under the Health Insurance Portability & Accountability Act of 1996 ('HIPAA"), I have certain rights to privacy regarding my protected health information, I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among multiple health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have read and understood your "Notice of Privacy Practices" containing a more complete description of the uses and disclosure of my health information. I understand that this organization has the right to change its "Notice of Privacy Practices" from time to time and that I may contact this organization at any time to obtain a current copy of the "Notice of Privacy Practices".
I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations.
INITIAL:_____

Authorization of release of information: I authorize Crown Valley Imaging to release any information regarding diagnosis and treatment to the insurance company or companies necessary to collect benefits under the policies stated at the time of treatment, or any policies, which I subsequently make a claim against for services, including related physician's services on this or a related date of service.
INITIAL:_____

Statement of Financial Responsibility: I agree to pay Crown Valley Imaging for any and all charges for services rendered. All Crown Valley Imaging accounts are due at time of service, however, I understand that Crown Valley Imaging will bill my insurance company as a courtesy to me and collect the assigned insurance benefit. I understand that if I have an outstanding deductible and/or patient responsibility as stated in my insurance benefit, that amount is owed Crown Valley Imaging and I will be billed for the amount. I understand that my insurance may deny my claim and the full amount will be owed to Crown Valley Imaging. I agree to pay for all outstanding balances not covered by my insurance. I agree that it is my responsibility to understand my insurance policy. I realize that Crown Valley Imaging may take whatever steps necessary to collect the balance due, including the use of a collection agency. I acknowledge that I have received a copy of Crown Valley Imaging's Financial Policies and agree to all terms.
INITIAL:_____

All the information provided on this form is correct and true. I acknowledge and understand the contents and agree to the statements above.

SIGNATURE_____ **DATE:** _____

PRINT NAME:_____
(Patient's signature or person authorized to consent for Patient/Relationship to Patient)

RETURN VISITS ONLY

I acknowledge the above information provided on this form is correct and there have been no changes since my last visit on:_____

SIGNATURE:_____ **DATE:**_____

Crown Valley IMAGING
Excellence in Imaging

AUTHORIZATION FOR RELEASE OF RECORDS

This form shall serve as authorization to obtain your prior imaging/diagnostic records from another facility or physician to Crown Valley Imaging. The reason for this request is to provide all previous information of your prior imaging history to our radiologists for the purpose of comparison.

Patient Name: _____

Date of Birth: _____ Phone number: _____

1. Name of Facility/Doctor/Hospital:

   _____

   Address:_____

   Phone: _____ Fax: _____

2. Name of Facility/Doctor/Hospital:

   _____

   Address:_____

   Phone: _____ Fax: _____

I HAVE READ AND UNDERSTAND THE ABOVE STATEMENTS AND AUTHORIZE THE DISCLOSURE OF THE INFORMATION REQUESTED ABOVE.

EXPIRATION OF AUTHORIZATION: I understand that this medical records authorization may be revoked in writing at any time. This authorization expires 1 year after date of signature.

Patient or Legal Representative Signature: _____ Date: _____

(FOR OFFICE USE ONLY)

Crown Valley Imaging is requesting:

_____ **CD (DICOM format Only) & Reports** _____ **Reports Only**

On the following diagnostic exams: _____

For prior date(s) of service: _____

Date of request: _____

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Excellence in Imaging

INFORMED PATIENT CONSENT FOR MYELOGRAPHY

Patient Name: _____

This is an "Informed Consent Form". It's purpose is to inform you about the diagnostic of therapeutic procedure your physician has recommended for you. You should read this form carefully and ask questions before you decide whether or not to give your consent for this procedure.

1. **PURPOSE OF THIS PROCEDURE:** A myelogram is performed to evaluate your spinal canal, spinal cord and/or spinal nerves.

2. **DESCRIPTION OF THIS PROCEDURE:** You will be asked to lie on a radiographic table. Your low back or upper back will be cleaned with and iodine-containing solution. A radiologist will perform the examination with the help of a trained technologist. A small amount of anesthetic will be injected in the skin of your neck or low back. A needle will then be placed into your spinal canal. This part of the procedure is midly to moderately uncomfortable but usually only lasts a few seconds. A special iodine-containing medication will then be slowly injected into your spinal canal and a series of images of your spine will be performed. The medication placed in your spinal canal allows the spinal cord and nerves to be seen on CT scans. Your body will eliminate this medication naturally.

3. **REASON FOR SELECTION:** Your physicianhas recommended that you undergo a myelogram because he or she has judged this test will be most useful in providing important diagnostic information about your spine. You have discussed the reasons for performing a myelogram with your physician.

4. **ALTERNATIVES:** Alternative methods for imaging the spine include standard X-rays, CT scanning (computed tomography) and MRI (Magnetic Resonance Imaging). You are aware of these alternatives, but your physician has recommended a myelogram rather than or in addition to one of these other tests.

5. **RISKS:** The most common adverse reaction from a myelogram is a headache, which occurs in 10% to 30% of patients. Occasionally, this headache may be severe and may last several days. Rare complications that may occur include: back pain, nausea, allergic reaction to the injected medication, nerve injury, infection, bleeding and seizures.

6. **DRIVING AFTER A MYELOGRAM:** You should not drive any motor vehicle until the day after this myelogram is performed.

7. **ALLERGIES/ BLEEDING PROBLEMS:** You must notify the physician performing this myelogram before the test if you have allergies to iodine or any other medication, if you have a history of excessive bleeding or if you are taking medication such as (Aspirin, Coumadin or Heparin) which might increase your risk of bleeding.

Your signature on this form indicates (1) that you have read and understand the information provided in the form, (2) that you have been verbally informed about this procedure by the physician, (3) that you have had a chance to ask questions, (4) that you have received all of the information you desired concerning the procedure and (5) that you authorize consent to the performance of the procedure.

PATIENT SIGNATURE : _____ DATE: _____

(Patient's signature or person authorized to consent for Patient/Relationship to Patient)

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CT Myelogram

What is CT Myelogram?

It is an imaging technique performed for high resolution evaluation of the spinal canal and cord. It requires injection of Iodinated contrast material into the space surrounding the spinal cord via a lumbar puncture followed by CT imaging of the area of interest. The procedure is performed by the radiologist.

What if I am on blood-thinners?

Let us know. Some medications like Aspirin or NSAIDS do not need to be stopped. However, other types of blood thinners need to be stopped before the procedure. Sometimes labwork is required to confirm that the effects of blood thinners are below a safe level.

What if I have a blood disorder or liver disease?

Blood work including CBC (complete blood count) and PT/PTT/INR within 1 week of the procedure is required.

What are the side effects?

Most patients do not experience any side effects. Approximately 1 out of 10 patients may experience a mild headache. If the headache becomes severe, it may require treatment. As with any surgical procedure, infection and bleeding may occur.

What should I do on the day of my procedure?

Do not eat for 4 hours prior to your scheduled time. You may take medication with small sips of water. Arrive 15 minutes before your appointment. The procedure can take 1-2 hours. Someone has to drive you home.

What should I do after my procedure?

Stay hydrated. You may resume your blood thinners. Lie down and rest as much as possible, keeping your head elevated with two pillows for 24 hours. No exercise or heavy lifting for 24 hours. Please call us with any questions at 949-367-1010.

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SPINE

Date _____ **Patient Name**_____

Date of Birth_____ **Male/Female** **Height** _____ **Weight** _____

1. Back pain YES / NO Where _____
2. Neck pain YES / NO Where _____
3. Leg pain YES / NO RIGHT / LEFT – Worse on RIGHT / LEFT
4. Arm pain YES / NO RIGHT / LEFT – Worse on RIGHT / LEFT
5. Numbness LEGS / ARMS YES / NO RIGHT / LEFT – Worse on RIGHT / LEFT
6. Weakness LEGS / ARMS YES / NO RIGHT / LEFT – Worse on RIGHT / LEFT

Personal history of cancer YES / NO If yes, what type, when and what treatment did you have? _____

_____

Describe your pain (Please circle) *SHARP* *BURNING* *DULL* *ACHING* *TINGLING*

Other, describe: _____

Please describe your symptoms_____

_____

How did the problem occur? (Please circle) **LIFTING** **WORK ACCIDENT** **ILLNESS** **SURGERY** **CAR ACCIDENT**

Please describe _____

How long have you had these symptoms? ____Suddenly ____Days ____Weeks _____Months ____ Years

Have you had previous spine surgery? YES / NO **If yes, what type of surgery and when?** _____

_____

Have you had a previous MRI of this area? YES / NO **If yes, where and when?** _____

_____

List any food or drug allergies _____

History of Diabetes YES / NO **If yes, what medications** _____

Please list any medications you are currently taking:

_____

_____

PLEASE SHADE IN THE AREA(S) WHERE YOU ARE HAVING A PROBLEM(S)