

Patient Registration Form
IF THIS FORM IS NOT COMPLETE, WE CAN NOT BILL YOUR INSURANCE

LEGAL NAME (Please PRINT legibly!!)		CCI#: _____ <small>(for office use only)</small>
Patient Name: _____		First Visit? YES NO
Address: _____		City/St/Zip: _____
Home Phone: () _____		Cell: () _____
		Work: () _____
SS#: _____		D.O.B. _____
		Sex: M F
		Marital Status: S M D W
Employer: _____		Address: _____
Occupation: _____		Full Time / Part Time / Student
Emergency Contact: _____		Phone: () _____
Relationship: _____		
Referring Physician: _____		Primary Physician: _____
Who will be responsible for your account? Self / Spouse / Father / Mother / Other _____		
Name: _____		SSN: _____
		Phone: () _____
Address: _____		City/St/Zip: _____
Employer: _____		Phone: () _____
<u>Primary Insurance Information:</u>		<u>Secondary Insurance Information:</u>
Ins Co Name: _____		Ins Co Name: _____
Address: _____		Address: _____
Policy Holder Name: _____		Policy Holder Name: _____
Relationship to Patient: _____		Relationship to Patient: _____
Policy Holder's Employer: _____		Policy Holder's Employer: _____
SSN/ID#: _____		SSN/ID#: _____
Policy/Group#: _____		Policy/Group#: _____
Policy Holder's Birthdate: _____		Policy Holder's Birthdate: _____
Work Related? YES NO		Is an attorney involved? YES NO
Auto Accident? YES NO		Attorney Name: _____
Injury Date: _____		Address: _____
		Phone: () _____
ASSIGNMENT OF BENEFITS: I hereby authorized Cherry Creek Imaging Center to release and/or obtain any information necessary to process insurance claims for services rendered to me or my dependent. I also authorize benefits to be paid directly to Cherry Creek Imaging Center. I understand that I will be responsible for co-pays, deductibles and any balances remaining after insurance has paid.		
Signature: _____		Date: _____

PAYMENT AND BILLING POLICY

TO OUR PATIENTS:

To help answer questions you may have, we have outlined our payment policies below. Please feel free to discuss these with us at any time should you have additional questions.

INSURANCE:

As a courtesy to our patients, we will bill all private companies directly; Blue Cross, Aetna, Pacificare, Cigna, Medicare, Medicaid, and all other commercial insurances. Cherry Creek Imaging Center is a preferred provider for most PPO and HMO plans. Let us know if you have questions regarding a particular plan. **You will need to provide our office with your current insurance card(s).** We cannot wait for payment pending third party litigation settlement (i.e. automobile accidents, attorney liens).

Medicare Patients:

As a policy, we do accept assignment for Medicare accounts. We will bill Medicare for you and payment will be sent directly to us.

PAYMENT POLICY:

Accounts are due and payable within thirty days after your insurance has responded to your claim. Self-pay patients will be asked for a portion of their balance at the time of service. Payment arrangements can be made if necessary on the remaining balance. We accept cash, personal checks and all major credit cards. Past due accounts may be turned over to a collection agency. A \$20.00 charge will be applied for NSF checks returned by your bank.

We understand that financial problems do arise from time to time. Let us know if you need to arrange a payment program that will help resolve your balance in monthly installments. Our Accounts Manager will gladly assist you with these arrangements.

Please remember, although you have an insurance claim pending, you are responsible for you deductible and co-payments. Your cooperation and understanding are appreciated. We would be happy to respond to any questions regarding our payment policy on your account. Please contact us at (303) 355-4674, or call our billing office directly at (303) 468-1395 with your inquiries.

Patient/Guarantor Signature

Date

PLEASE PRINT THE FOLLOWING INFORMATION:

Patient: _____ DOB: ____/____/____ CCI#: _____
(Last Name) (First Name) (Middle Initial/Name) (mm/dd/yyyy) (For office use only)



210 University
 Suite 102
 Denver, Colorado 80206
 303-355-4MRI
 fax 303-355-7865
 www.cherrycreekimaging.com

CHERRY CREEK IMAGING CENTER

CONSENT FOR USE AND DISCLOSURE OF PRIVATE HEALTHCARE

INFORMATION FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

PATIENT: _____ DOB: ____/____/____

SSN: _____ Other Name: _____ CCI#: _____

My health information is a private matter. Cherry Creek Imaging Center has a form that can tell me how Cherry Creek Imaging Center handles my health information. This form is called "Notice of Privacy Practices". If I ask, Cherry Creek Imaging Center will be happy to provide me with the most current "Notice" before I sign this consent. Cherry Creek Imaging Center may update this "Notice" at any time. If I ask, I may obtain a copy of the most current "Notice".

I agree that Cherry Creek Imaging Center may use and disclose my health information to help treat me. I agree that Cherry Creek Imaging Center may use and disclose my information for billing and payment. I also agree to uses and disclosures of my health information to take care of other health care operations. In general, no other uses or disclosure of my health information will occur unless I tell Cherry Creek Imaging Center it's okay to do so. Sometimes the law may allow the release of information without my permission. These situations are unusual. One example would be if a patient threatened to hurt someone.

I may cancel this consent at any time, by doing one of the following:

- Signing and dating a revocation form. I may get this form from Cherry Creek Imaging Center; or
- Writing, signing, and dating a letter to Cherry Creek Imaging Center. The letter must say I cancel my consent to authorize the use and disclosure of my health information for treatment, payment and health care operations.

If I cancel this consent:

- It will be effective except for actions already taken based upon the consent and
- Cherry Creek Imaging Center will not have to provide any more health care services to me.

I have been given the chance to read a current copy of Cherry Creek Imaging Center's "Notice of Privacy Practices". I agree to allow Cherry Creek Imaging Center to use and disclose my health information to carry out treatment, payment and health care operations.

 Patient or legally authorized individual signature

 Date

MRI PATIENT SCREENING FORM

Patient Name: _____ Date: ____/____/____
(Last) (First) (Middle)

Date of Birth: ____/____/____ Age: ____ Height: ____ Weight: ____ Male ____ Female ____

Referring Physician: _____ Referring Physician Phone (____) ____ - ____

Body Part to be Examined: _____ **R L** (circle R or L if applicable)

Reason for exam/Symptoms: _____

1. Have you had a prior surgery of any kind? **___No ___Yes**
If yes, please list all with dates: _____
2. List previous diagnostic imaging studies (MRI, CT, US, X-ray, etc): _____
3. Have you experienced any problem related to a previous MRI examination? **___No ___Yes**
4. Have you had an injury to the eye involving a metallic object (metallic slivers, shavings, etc.)? **___No ___Yes**
If yes, please describe: _____
5. Have you ever been injured by a metallic object (BB, bullet, shrapnel, etc.)? **___No ___Yes**
If yes, please describe: _____
6. Please list current or recent medications or drugs: _____
7. Please list any medication allergies: _____
8. Have you ever had an allergic reaction to an IV contrast material used for MRI, CT, or X-ray? **___No ___Yes**
If yes, please describe: _____
9. Are you being treated for **chronic renal disease** and/or on **dialysis**? **___No ___Yes**
If yes, please describe: _____
Name and phone number of physician treating you for this condition? _____

Female Patients:

10. Date of last menstrual period: ____/____/____ Post Menopausal? **___No ___Yes**
11. Are you pregnant or experiencing a later menstrual period? **___No ___Yes**
12. Are you taking oral contraceptives or receiving hormonal treatment? **___No ___Yes**
13. Are you taking any type of fertility medication or having fertility treatments? **___No ___Yes**
If yes, please describe: _____
14. Are you currently breastfeeding? **___No ___Yes**

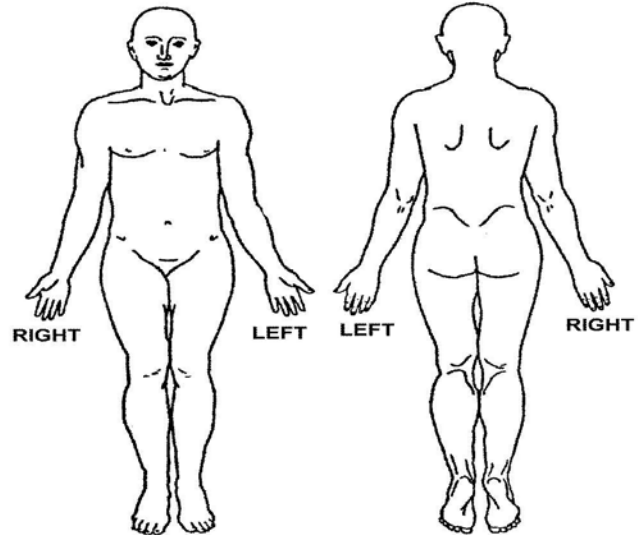


WARNING: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure (i.e., MRI, MR angiography, functional MRI, MR spectroscopy). Do not enter the MR system room or MR environment if you have any question or concern regarding an implant, device, or object. Consult the MRI Technologist or Radiologist **BEFORE** entering the MR system room. The MR system magnet is **ALWAYS** on.

Please indicate if you have any of the following:

- Yes No Aneurysm clip(s)
- Yes No Cardiac pacemaker
- Yes No Implanted cardioverter defibrillator (ICD)
- Yes No Electronic implant or device
- Yes No Magnetically-activated implant or device
- Yes No Neurostimulation system
- Yes No Spinal cord stimulator
- Yes No Internal electrodes or wires
- Yes No Bone growth/bone fusion stimulator
- Yes No Cochlear, otologic, or other ear implant
- Yes No Insulin or other infusion pump
- Yes No Implanted drug infusion device
- Yes No Any type of prosthesis (eye, penile, etc.)
- Yes No Heart valve prosthesis
- Yes No Eyelid spring or wire
- Yes No Artificial or prosthetic limb
- Yes No Metallic stent, filter, or coil
- Yes No Shunt (spinal or intraventricular)
- Yes No Vascular access port and/or catheter
- Yes No Radiation seeds or implants
- Yes No Swan-Ganz or thermodilution catheter
- Yes No Medication patch (Nicotine, Nitroglycerine)
- Yes No Any metallic fragment or foreign body
- Yes No Wire mesh implant
- Yes No Tissue expander (e.g., breast)
- Yes No Surgical staples, clips, or metallic sutures
- Yes No Joint replacement (hip, knee, etc.)
- Yes No Bone/joint pin, screw, nail, wire, plate, etc.
- Yes No IUD, diaphragm, or pessary
- Yes No Dentures or partial plates
- Yes No Tattoo or permanent makeup
- Yes No Body piercing jewelry
- Yes No Hearing aid
- Yes No *(Remove before entering MR system room)*
- Yes No Other implant _____
- Yes No Breathing problem or motion disorder
- Yes No Claustrophobia

Please mark on the figure(s) below the location of any implant or metal inside of or on your body.



IMPORTANT INSTRUCTIONS

Before entering the MR environment or MR system room, you must remove all metallic objects including hearing aids, dentures, partial plates, keys, beeper, cell phone, eyeglasses, hair pins, barrettes, jewelry, body piercing jewelry, watch, safety pins, paperclips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clipper, tools, clothing with metal fasteners, & clothing with metallic threads.

Please consult the MRI Technologist or Radiologist if you have any question or concern **BEFORE you enter the MR system room.**

NOTE: You may be advised or required to wear earplugs or other hearing protection during the MR procedure to prevent possible problems or hazards related to acoustic noise.

I attest that the above information is correct to the best of my knowledge. I read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form and regarding the MR procedure that I am about to undergo.

Signature of Person Completing Form: _____ Date ____/____/____
Signature

Form Completed By: Patient Relative Nurse _____
Print name Relationship to patient

Form Information Reviewed By: _____
Print name Signature

MRI Technologist Nurse Radiologist Other _____