GO IMAGING

PATIENT INFORMATION / FINANCIAL RESPONSIBILITY

Name:_____ SSN: _____
Last First Middle Initial

Date of Birth:_____ Sex*: ☐M ☐F Marital Status: ☐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: ☐ FT ☐ PT ☐ Retired ☐ Not Employed
Company Name

Emergency Contact: _____
Name Relationship Phone

How did you hear about us? ☐ 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 JK Radiant, L.P. dba GO Imaging 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. I further authorize GO Imaging 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 to contact me via any of the methods I have provided.

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

GO IMAGING

Authorization for Use or Disclosure of Information

I, _____, hereby authorize ***JK Radiant, L.P. dba GO Imaging*** (hereafter ***GO Imaging***) 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 **notices@go-imaging.com**. I understand that a revocation is not effective to the extent that ***GO Imaging*** 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*** 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*** 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 ***JK Radiant, L.P. dba GO Imaging*** (hereafter ***GO Imaging***) for the purpose of providing services to me, obtaining payment for my health care bills or to conduct health care operations of ***GO Imaging***. I understand that service provided to me by ***GO Imaging*** 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*** is not required to agree to the restrictions that I may request. However, if ***GO Imaging*** agrees to a restriction that I request, the restriction is binding on ***GO Imaging***. I have the right to revoke this consent, in writing, at any time, except to the extent that ***GO Imaging*** has taken action in reliance on this consent.

I understand I have a right to review ***GO Imaging*** 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*** 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*** 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

PATIENT/INTERNAL
MR
(Circle one) **HF / OP**

MRI - TECH SHEET

Name: _____
Last First Middle

DOB: _____ Age:_____ Sex: □ M □ F Wt: _____ Ht: _____

Were you injured? □ Yes □ No If yes, when?_____

Describe your symptoms □ Aching □ Burning □ Pins and Needles □ Radiating □ Stabbing □ Weakness, etc.):

_____

Have you had any of the following ***related to this exam***? (please mark all that apply)
Surgery □ Cat Scans □ X-rays □ MRI's □

If yes, where, when and the results (for each)?

_____

Do you have any chronic illnesses? Diabetes: □ Yes □ No Hypertension: □ Yes □ No
Others (specify): _____

Do you or have you smoked? □ Yes □ No *If yes*, how much and for how long?_____

Do you or have you ever had cancer? □ Yes □ No

If yes, what type and treatments? _____

Yes	No	
		Cardiac Pacemaker
		Brain Surgery Clips/Aneurysm Clips
		Carotid Artery Clips
		Vascular Clamps
		Neurostimulators (TENS)
		Heart Valve
		Electrodes
		Hearing Aid
		I.U.D. Type:
		Shunt: ☐ Spinal or ☐ Ventricular
		Fractured bones or spine treated with:
		Metal Rod Location:
		Metal Plates Location:
		Metal Pins Location:
		Screws Location:
		Tattoos Location:
		Kidney disease
		Asthma
		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
		Middle Ear/ Cochlear Implant: ☐ L ☐ R
		Electronic Monitoring Device
		Medication Pump Type:
		Joint Replacement Location:
		Shrapnel / gunshot wound Location:
		Hepatitis
		Stents
		Other Metal Implants (please specify):

Has patient had any surgery other than dental? □ Yes □ No ***If yes***, please list type of surgery & date below:

_____

Female patients please answer the following questions:

Date of last menstrual period: _____ Any possibility of pregnancy? □ Yes □ No

Are you breast feeding? □ Yes □ No

Patient Signature:_____ ***Date:***_____

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

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

List all medications you are currently taking:

_____

Allergies? (If so, please list and include type of reaction.)

_____

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: _____