Patient Registration Form (PLEASE PRINT)

Sacramento IMAGING

For Office Use Only: Auto____ WC____ Self-Pay____

PATIENT INFORMATION

Patient Full Name: _____ **Patient's DOB**: _____
Last First Middle Initial

Patient's SSN: _____ **Gender**: M___ F____ **Marital Status**: S___ M___ D___ W___

Street Address: _____

City/State/Zip Code: _____

Phone 1: (_____) _____ Type: Home_____ Cell____

Phone 2: (_____) _____ Type: Home_____ Cell____

Ethnicity: Hispanic or Latino ____ Non-Hispanic or Latino ____ Other or Undetermined ____

Race: Asian____ Black or African American____ Caucasian____ American Indian or Alaskan Native____ Armenian____

Pacific Islander____ Native Hawaiian____ Filipino____ Japanese____ Multiracial____ Other____ Undetermined____

Emergency Contact Name:_____

Emergency Contact Phone: (____) _____ **Relationship to Patient**: _____

Email Address: _____

Please indicate below what type of information that may be shared at the email address you have provided above:

All ___ Scheduling/Appointment ____ Billing/Insurance ____ Health Related Newsletter _____ Medical Records _____

Employer: _____

Occupation: _____ Work Phone: (_____) _____

Employer Address: _____

City/State/Zip Code: _____

RESPONSIBLE PARTY INFORMATION

Who will be responsible for your account? Self _____ Other _____
(IF *SELF*, SKIP THIS SECTION)

Responsible Party Name: _____
Last First Middle Initial

Patient's Relationship to Responsible Party: _____

Responsible Party Street Address: _____

City/State/Zip Code: _____

Home Phone: (_____) _____ **Cell Phone**: (_____) _____

revision date: 07/2020

INSURANCE INFORMATION (Please provide Insurance Card & Photo ID to Front Desk)

Primary Insurance Company Name: _____

Insurance Address: _____

City/State/Zip Code: _____

Phone Number: (_____) _____

Member ID Number: _____ Group Number/Name:_____

Name of Policy Holder: _____
Last First Middle Initial

Policy Holder Date of Birth: _____ Policy Holder's SSN: _____ Relationship to Patient: _____

If you have Secondary Insurance, please complete this section:

Secondary Insurance Company Name: _____

Insurance Address: _____

City/State/Zip Code: _____

Phone Number: (_____) _____

Member ID Number: _____ Group Number/Name:_____

Name of Policy Holder: _____
Last First Middle Initial

Policy Holder Date of Birth: _____ Policy Holder's SSN: _____ Relationship to Patient: _____

ASSIGNMENT OF BENEFITS OTHER THAN MEDICARE: I hereby assign and authorize payments for services rendered to be paid directly to Sacramento Imaging. I understand that my insurance carrier(s) may not approve or reimburse my medical services in full due to usual and customary rates, benefit exclusions, coverage limits, lack of authorization or medical necessity. I understand that I am responsible for any charges not paid in full, co-payments, deductibles and co-insurance except where my liability is limited by contract or state or federal law. A photocopy of this document shall be as valid and as effective as the original.

FOR MEDICARE PATIENTS ONLY: I certify that the information given by me in applying for payment under Title XVII of the Social Security Administration or its intermediaries or carriers is the correct information needed for Medicare claims. I hereby authorize any holder of medical or other information about me to release to the Centers for Medicare & Medicaid Services or its agents, intermediaries or carriers any information needed to determine these benefits or the benefits payable for related services. I further understand that deductibles, coinsurance and any other charges not covered by Medicare are my responsibility.

RELEASE OF MEDICAL INFORMATION: I authorize Sacramento Imaging Imaging to release the medical records concerning myself or my dependent to any physician, hospital or agency involved in the care of the patient listed on this form.

PAYMENT POLICY: Co-payments, Co-insurance and deductibles will be collected at the time services are rendered. We accept cash, checks, and credit cards. You will be responsible for any balance deemed patient responsibility/non-payable/non-covered by your insurance.

COMMUNICATIONS AUTHORIZATION: I hereby consent to receive auto-dialed and/or pre-recorded telephone calls from or on behalf of Sacramento Imaging at the telephone numbers provided above, including my wireless number, if applicable. I understand that this consent is not a condition of receiving services from Sacramento Imaging.

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE. I HAVE READ, UNDERSTAND, AND AGREE TO ABIDE BY THE ABOVE RELEASE OF MEDICAL INFORMATION AND PAYMENT POLICIES.

Signature of Patient or Responsible Party: _____ Date: _____
(if under 18 yrs of age)

revision date: 07/2020

Informed Consent for Ultrasound

What is an ultrasound?

An ultrasound or sonogram obtains images from inside the human body through the use of high frequency sound waves. The reflected sound wave echoes are picked up and converted by a computer into an image that is displayed on a computer screen. An ultrasound test is painless, does not emit ionizing radiation and is one of the safest diagnostic medical examinations available today.

What happens during an ultrasound exam?

The sonographer applies an odorless, colorless gel to the skin above the body structure(s) to be studied. This gel helps conduct sound waves from the ultrasound transducer down to the tissues that are the focus of the study. The sonographer applies the transducer to the skin and short pulses of ultrasound waves are emitted and received.

For some scans, your doctor may instruct you not to eat or drink for as many as 8 hours before your appointment. For other exams, you may be asked to drink water so that your bladder is full when the scan begins.

As the transducer is moved around, an image of the various organs under study appears on a monitor. The sonographer then electronically stores the most diagnostically useful images. Selected images are used by the interpreting physician to make a final diagnosis.

What are some common uses of the procedure?

Ultrasound is used for evaluating the body's internal organs and can help a physician determine the source of pain, swelling or infection in many parts of the body. Because ultrasound provides real time images it can also be used to guide procedures such as needle biopsies, in which needles are used to sample cells from organs for laboratory testing.

What are the benefits vs. risks?

Ultrasound scanning is a noninvasive (no needles or injections) exam which is usually painless, widely available, and uses no ionizing radiation. It provides real time imaging, and can visualize structure, movement and live function in the body's organs and blood vessels. For standard diagnostic ultrasound there are no known harmful effects on humans.

What is Vascular Ultrasound?

Vascular Ultrasound Imaging is a way to evaluate the body's circulatory system. It helps radiologists monitor the blood flow to organs and tissues throughout the body, as well as to evaluate the placement and success of repair, such as after arterial bypass surgery. It can also help identify blockages and abnormalities and help plan for their effective treatment.

What is Breast Ultrasound?

Breast ultrasound is sometimes used to evaluate breast abnormalities that are found during mammography or a physical exam. Ultrasound is useful for some breast masses, and is the easiest way to tell if a cyst is present without placing a needle into the abnormality to draw out fluid.

What is a Transvaginal Ultrasound?

The transvaginal ultrasound is an important part of a routine pelvic ultrasound examination. During the procedure you will be draped and the technologist will carefully insert an ultrasound probe into the vagina about half an inch. The transvaginal ultrasound permits better visualization of the ovaries and uterus, does not require a full bladder, and is not affected by body mass. Normally a routine transabdominal examination of the pelvis is performed first. Afterward you will be asked to completely empty the bladder before the transvaginal exam is performed. The exam takes about 10 minutes. There are no known risks to the transvaginal ultrasound and no known bioeffects.

Alternatives to Ultrasound

For visualization of bone, other imaging modalities such as magnetic resonance imaging (MRI) may be selected.

By signing this you agree that you have read this form and/or I have received oral communications of all the information provided in this form. You understand the information, and have had any questions answered regarding this procedure and who will read the exam. In addition, you agree that you 1) have been explained the purpose of the procedure; 2) have been informed of how long the procedure will take; 3) understand the risks, benefits, and complications associated with the procedure; 4) have truthfully informed Sacramento Imaging of my current medical condition and have complied with any require-ments for having this procedure that have been communicated to me; 5) are aware of possible alternatives; and 6) have been given the right to refuse to consent to the procedure.

I have not been pressured to sign this consent and do so voluntarily. I understand that I may contact Sacramento Imaging at the address and phone number provided if I have any further questions about this form or the procedure. I am at least 18 years of age, of sound mind and not under the influence of alcohol or hallucinogenic drugs. I have no reservations and give my consent to start and complete the exam(s) by my signature and date here.

Patient's and/or Appropriate Agent's Signature _____ **Date:** _____

PATIENT HEALTH HISTORY

Patient name:_____ Date:_____

Your answers on this form will help your technician get an accurate history of your medical concerns and conditions. If you can't remember specific details, please provide your best guess.
REVIEW OF SYMPTOMS: Please check mark any persistent symptoms you have had in the past few months. Read through every section and check mark "no problems" if none of the symptoms apply to you.

GENITOURINARY
__Leaking urine
__Blood in urine
__Increased urination
__Discharge penis or vagina
__Other
__No Problems

INFECTIONS
__MRSA
__Hepatitis
__HIV/AIDS
__Tuberculosis
__Other
__No Problems

NEUROLOGICAL
__Headaches
__Memory loss
__ Fainting/Dizziness
__Numbness/Tingling
__Other
__No problems

EARS/NOSE/THROAT
__Nosebleeds/Trouble swallowing
__Frequent sore throat/Hoarseness
__Hearing loss/Ringing in ears
__Other
__No problems

RESPIRATORY
__Cough/Wheezing
__Shortness of breath
__Altered breathing
__Other
__No problems

GENERAL
__Unexplained weight loss
__Unexplained fatigue
__Fever/Chills
__Other
__No problems

GASTROINTESTINAL
__Heartburn/Reflux/Indigestion
__Blood/Bowel movement changes
__Constipation
__Other
__No problems

MUSCULOSKELETAL
__Neck pain
__Back pain
__Muscle/Joint pain
__Other
__No problems

HEMATOLOGICAL/ LYMPHATIC
__Swollen glands
__Easy bruising
__Other
__No problems

CARDIOVASCULAR
__Chest pain/discomfort
__Palpitations
__Other
__No problems

ENDOCRINE
__Heat or cold sensitivity
__Other
__No problems

SKIN
__Rash/Itching
__Other
__No problems

WOMEN ONLY
Are you pregnant?__ YES, __NO, If NO, when was your last menstrual cycle?_____
___Problems with menstruation ____Other ____No problems

_____

_____
Patient Signature

HIPAA Acknowledgment

Patient Consent for Use/Disclosure of Protected Health Information

Patient Name: _____ Date of Birth: _____

Social Security #: _____ Previous Name (if applicable): _____

I understand that my/the patient's health information is private and confidential. I understand that Sacramento Imaging works hard to protect my/the patient's privacy and preserve the confidentiality of my/the patient's personal health information. I understand the Sacramento Imaging may use and disclose my/the patient's health information to provide treatment to me/the patient, to handle billing and payment, and to take care of other healthcare operations. In general, there will be no other uses and disclosures of this information unless I/ the patient permit it. I understand that sometimes the law may require the release of this information without my permission. These situations are very unusual, but one example would be if a patient threatened to hurt someone.

Sacramento Imaging has a detailed document called the "Notice of Privacy Practices". It contains more information about how we may use and disclose patient health information. I understand that I have a legal right to read the "Notice" before I sign this consent.

Sacramento Imaging may update the "Notice of Privacy Practices". If I ask, Sacramento Imaging must provide me with the most current "Notice".

Under the terms of this consent, I can ask Sacramento Imaging to restrict how my/the patient's protected health information is used or disclosed to carry out treatment, obtain payment, or other healthcare operations. I understand that Sacramento Imaging does not have to agree to my/the patient's request if it interferes with any of the above.

I may cancel this consent at any time by writing, signing, and dating a letter to Sacramento Imaging. If I write a letter, it must specifically state that I want to revoke my/the patient's consent for authorization to use/disclose health information for treatment, payment, and other healthcare operations.

My signature below indicates that I have been given the option to read and review a current copy of Sacramento Imaging's If I revoke this consent or do not agree to sign this consent form, Sacramento Imaging does not have to provide any healthcare services to me/the patient. "Notice of Privacy Practices".

My signature means that I agree and consent to allow Sacramento Imaging to use/disclose my/the patient's protected health information to carry out treatment, obtain payment, and any other additional healthcare operations.

Relationship to Patient_____

Relationship to Patient_____

Relationship to Patient_____