

Expo Pointe
Imaging Center

Patient Registration Form

Patient Name: _____ Male: _____ Female: _____

Date of Birth: _____

Patient Address: _____

City, State, ZIP: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Pager No: _____

E-mail Address: _____

Parent/Responsible Party: _____

Address, If Different Than Patient: _____

Primary Language: _____

Marital Status of Parents: _____

Custodial Parent(s): (If divorced, please provide proof of custody) _____

Legal Guardian(s): (If other than parents, please provide proof of guardianship) _____

Referring/Primary MD: _____ Phone #: _____

Parent/Responsible Party Information:

Employer: _____

Driver's License #: _____

Emergency Contact: _____

Address and Phone #: _____

Primary Insurance	Secondary Insurance

Consent for Treatment: I authorize all medical or surgical procedures, tests or treatments ordered by my physician.

Release of Information: I authorize the release of medical information to my referring physician, insurance company, and/or legal guardian.

Assignment of Benefits: If my child is covered by an acceptable insurance, I authorize benefits to be paid directly to Shailesh M. Asaikar, M.D. Inc.

By signing below, I agree to all terms and conditions stated above, including the attached **Financial Policy Agreement for Expo Pointe Imaging Center.**

Parent/Responsible Party Signature

Date

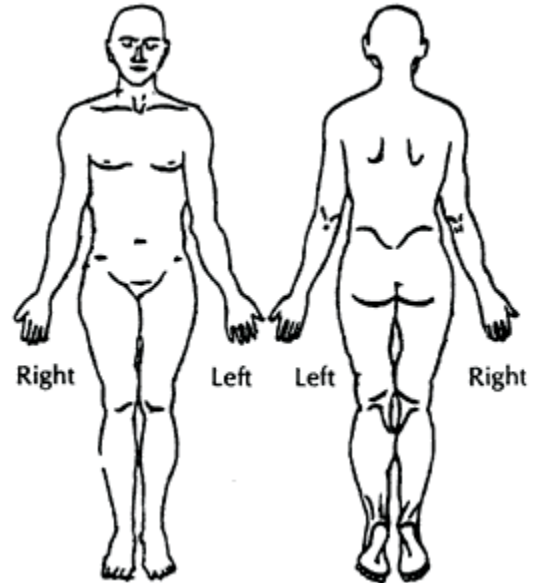


WARNING: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure (i.e., MRI, MR angiography, functional MRI, MR spectroscopy). Do not enter the MR system room or MR environment if you have any questions or concerns regarding an implant, device, or object. 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 (Remove before entering MR 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 month day year

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

Form Information Reviewed By: _____
Print name Signature

- MRI Technologist Nurse Radiologist Other _____



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1111 Exposition Blvd., Bldg. 700, Suite 102
Sacramento, CA 95815
P: 916. 779. 1018
F: 916. 649. 9801
F: 916. 779. 2591

www.expopointemri.com

Expo Pointe Imaging Center Payment Policies

Health and accident policies are an arrangement between you and your insurance company. We bill your insurance as a courtesy to you. It is the patient's responsibility (or the parent if the patient is a minor) to know the requirements of your particular insurance policy and the facilities that they are allowed to use in order to receive the best possible benefits.

The patient is responsible for any co-payments and/or deductibles including services not covered by your insurance plan, as well as the amounts the insurance carrier denies as the patient's responsibility.

Please be prepared to pay for plan co-payments/deductibles/co-insurance at the time of service.

By signing below, I agree to all terms and conditions stated above.

Child's/Patient's Name: _____

Patient/Parent Signature: _____

Date: _____