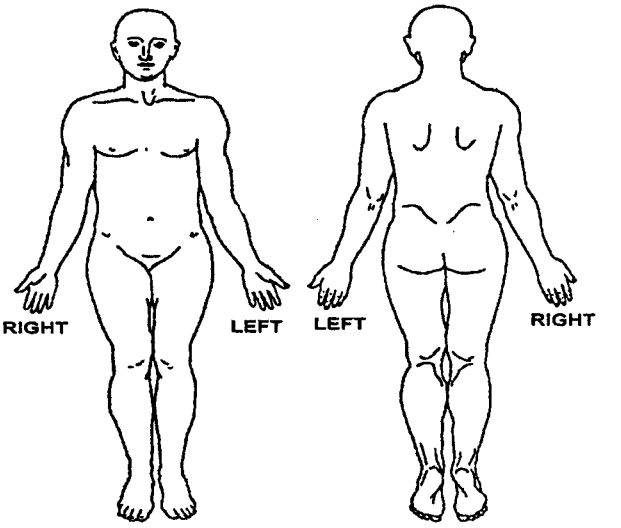
WARNING: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure (i.e., MRI, MR angiography, functional MRI, MR spectroscopy). Do not enter the MR system room or MR environment if you have any question or concern regarding an implant, device, or object. 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 Are you here for an MRI examination?
- ☐ 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 system room)
- ☐ Yes ☐ No Other implant _____
- ☐ Yes ☐ No Breathing problem or motion disorder

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.

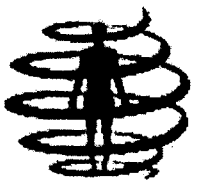
I attest that the above information is correct to the best of my knowledge. I read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form and regarding the MR procedure that I am about to undergo.

Signature of Person Completing Form: X _____ 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_____



COASTAL IMAGING

MRI/CT CONSENT FORM

On certain studies, a contrast agent (oral or intravenous contrast, or both) is needed to help with the interpretation of the study. In a small percentage of cases, complications (side effects) can occur from any contrast study. Reactions include headaches, nausea, vomiting, swelling, sneezing, hives, dizziness, weakness, fever or seizures. The possibility of a more serious reactions including life threatening or death is extremely rare, but should always be considered.

If you wish to refuse the contrast agent simply, inform the technologist, however without the contrast agent your images may not be as detailed or helpful to the radiologist and your physician.

*****Please inform the technologist if you have previously had a reaction to IV contrast or have a history of kidney disorder and or liver disorder.******

If you have any further questions regarding this procedure or its possible risks, you should discuss them with the technologists once you are called back for your study. You are asked to sign this form to verify you understand the indications for the MRI/CT and possible complications and to consent to the MRI/CT procedure and or the injection of a contrast agent.

X _____ _____

PATIENT OR GUARDIAN SIGNATURE WITNESS

COASTAL IMAGING

Patient Information Form

Date:_____

☐ Male ☐ Female

Name:_____ Date of Birth:_____SSN:_____

Mailing Address:_____

City:_____ State:_____Zip:_____

Home Phone:_____Work Phone:_____Cell phone:_____

Name of Parent/Guardian (for minors only):_____Phone:_____

Address (if different from patient):_____

Emergency Contact Name:_____Contact Number:_____

Patient Guarantor Employer Information

Employer's Name:_____Address:_____
Occupation:_____Phone:_____

Responsible Party

Primary Insurance:_____SecondaryInsurance:_____

Assignment and Release:

The signature below serves as authorization for the release of medical information from patient's other healthcare providers for purpose of treatment and for services rendered by Coastal Imaging for the above named patient. This signature will also serve as a release of information necessary to file insurance and assign benefits otherwise payable to policy holder, to the physician or group indicated on the claim. I authorize direct payment from my insurance company to Coastal Imaging. I understand I am financially responsible for any balance not covered by the insurance carrier.

We will file non-contracted insurance as a courtesy: however, if we have no response from your insurance company within 60 days, the charges will be transferred to your responsible party.

Signature:X_____Date:_____

For office use only:_____Date:_____

COASTAL IMAGING

Patient Financial Policy

Thank you for choosing our imaging center. We are committed to providing the best possible medical care. The following information is provided to avoid any confusion regarding payment for professional medical services.

Payment Policy

- You will receive one bill for services provided at Coastal Imaging that includes the exam performed and professional interpretation.
- Payment is due at the time services are rendered unless other arrangements have been made by either you or your insurance company.
- We accept cash, check, Visa and MasterCard.
- Patients are responsible for their deductible or charges not reimbursed by insurance.
- If the patient is a minor (18 years or younger), the parent or guardian is responsible for payment of the account, accordance with policy outlined above.
- As a courtesy, we will automatically file your insurance claims; therefore we will request a copy of your insurance card at the time of each visit.
- For services estimated to cost more that $200.00, we will accept a minimum payment of half of the expected bill. Upon request, a short-term payment arrangement can be considered.
- You will receive monthly statements. If your account is not paid within 60 days your account will be considered past due.
- Patients having health insurance will be expected to contact their insurance carrier if there is a delay in payment. Please understand that insurance is a contract between you and your carrier, therefore, you are ultimately responsible for your bill.
- If you have difficulty paying your account, please contact our billing department.
- In cases of divorce, the parent who brings the child/children in for treatment is responsible for payment: there are no exceptions.

Referrals

It is your responsibility to bring any required referrals for treatment at, or prior to, the time of your visit. If you do not have a referral, your visit will be rescheduled, or you may be financially responsible.

Acknowledgment and Authorization

I have read, understand and agree to the above policies. I understand the charges not covered by my insurance company, as well as co-payments and deductibles are my responsibility.

I authorize my insurance benefits be paid directly to Coastal Imaging.

I authorize Coastal Imaging to release any medical or other information to my insurance company when requested.

Patient Name X _____ Date _____

Patient's Signature X _____ Parent/Guardian _____
(If patient is a minor)

COASTAL IMAGING

Patient Record of Disclosures

In general, HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of protected health information (PHI). The individual is also provided the right to request confidential communications of PHI by alternative means, such as sending correspondence to the individual's office instead of their home.

I wish to be contacted in the following manner: (Check all that apply)

__ Work telephone __Ok to leave message with detailed information

__ Home telephone __Ok to leave message with detailed information

__ Written communication __ Ok to mail to my home address

***Please list only persons able to discuss treatment, appointments, release prescriptions and/or medical records on your behalf in your absence. Note: All persons listed must present valid ID when acting as your representative.

Please print authorized persons only:

1._____ __Appts ___RX __All records

2._____ __Appts __RX __All records

3._____ __Appts __RX __All records

Patient's signature: X_____ Date:_____

Acknowledgement and Receipt of HIPAA Policies and Procedures

I _____ hereby acknowledge that I have received and reviewed the HIPAA policies and procedures, detailing how information may be used and disclosed as permitted under federal and state law.

I understand that I am responsible for complying with the policies and procedures and that I am required to see guidance from the Privacy Officer if I have any question or concerns regarding patient confidentiality.

Patient/Guardian signature X_____ Date:_____

Witness:_____ Date:_____