



Radiology Department Patient Registration

Patient Label

Please provide your driver's license or photo ID and insurance card at time of registration.

| | | | |
|----------------------|----------------------|----------------------|---|
| Patient Last Name | First Name | MI | Date of Birth |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> MM / <input type="text"/> DD / <input type="text"/> YYYY |

| | | |
|--|---|--|
| Social Security Number | Gender | Email Address (to access your records and for satisfaction survey) |
| <input type="text"/> - <input type="text"/> - <input type="text"/> | M <input type="checkbox"/> F <input type="checkbox"/> | <input type="text"/> |

| | | | | |
|----------------------|-------------------------|---|--------------------------|--------------------------|
| Responsible Party | Relationship to Patient | Patient's Mobile Phone | Call | Msg |
| <input type="text"/> | <input type="text"/> | <input type="text"/> () - <input type="text"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| | | | | |
|----------------------|----------------------|---|--------------------------|--------------------------|
| Address | Apartment # | Patient's Home Phone | Call | Msg |
| <input type="text"/> | <input type="text"/> | <input type="text"/> () - <input type="text"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| | | | | | |
|----------------------|----------------------|----------------------|---|--------------------------|--------------------------|
| City | State | ZIP | Work or Other Phone | Call | Msg |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> () - <input type="text"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| | | |
|----------------------|---|---|
| Emergency Contact | Emergency Contact Phone 1 | Emergency Contact Phone 2 |
| <input type="text"/> | <input type="text"/> () - <input type="text"/> | <input type="text"/> () - <input type="text"/> |

May we send mail to your home address? Yes / No If not, please provide an alternate mailing address:

street or p. o. box apt. # city state zip

| | | | | |
|----------------------|----------------------|---|----------------------|----------------------|
| Insurance | Subscriber Name | Subscriber DOB | Group Number | Policy Number |
| <input type="text"/> | <input type="text"/> | <input type="text"/> MM / <input type="text"/> DD / <input type="text"/> YYYY | <input type="text"/> | <input type="text"/> |

| | | |
|---|----------------------|----------------------|
| If Accident: Date | Time | Accident Details |
| <input type="text"/> MM / <input type="text"/> DD / <input type="text"/> YYYY | <input type="text"/> | <input type="text"/> |

Work Related? Yes No Employer Employers Phone () -

Religious Preference Preferred Language

Other than you, your insurance company and healthcare providers involved in your care, with whom can we share your healthcare information? (Please enter all that apply.)

| Name | Phone Number | Relationship |
|----------------------|---|----------------------|
| <input type="text"/> | <input type="text"/> () - <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> () - <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> () - <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> () - <input type="text"/> | <input type="text"/> |

Do you have any health information that you would like to be kept confidential from any person or persons? If so, please specifically describe the information and person or persons below:

I hereby verify the above information is true and correct.

Patient or Legal Guardian Signature Date / / Time

Witness Signature Date / / Time



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CONSENT FOR TREATMENT: I, the undersigned, request and authorize **Baylor Medical Center at Uptown**, and all its physicians, surgeons, technicians, nurses, and other qualified personnel, whether employed directly by the hospital or brought in on a consulting basis, to provide any medical/surgical treatment, diagnostic tests and hospital care which the attending physician or designee(s) may deem necessary or beneficial for my health. Initial

FINANCIAL AGREEMENT: We wish to stress that the financial responsibility for services rendered rests with the patient and his/her family, regardless of any insurance coverage. Your insurance policy is a contract between you and your insurance company. We cannot guarantee payment of your claim. If it is not paid, the insurance company should explain to you why it was rejected. Most of the time our fees fall within their "usual and customary" guidelines, however, the responsibility for the balance of this account falls on you. Initial

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize payment directly to **Baylor Medical Center at Uptown** and any physicians, including, but not limited to ER physicians, radiologists, etc. of the insurance benefits specified and otherwise payable to me, but not to exceed the Hospital's regular charges for these services. Initial

RELEASE OF INFORMATION: I authorize **Baylor Medical Center at Uptown** and any physicians involved in my care to release medical information and supporting documentation of same as compiled in my medical records during this emergency department visit to any organization which is, or may be liable or responsible for payment of charges associated with my care, and for all other purposes of benefit payment. If my injury is work-related, I authorize **Baylor Medical Center at Uptown** to release any information from my medical records to my employer and/or its designee. Initial

PHYSICIANS SERVICES: Emergency Department physicians, radiologists, pathologists, surgeons, etc. are independent contractors, and are not employees of **Baylor Medical Center at Uptown**. Physicians' services are billed separately. Initial

PERSONAL ITEMS and MEDICATIONS: I understand that **Baylor Medical Center at Uptown** is not responsible for lost or stolen personal or valuable items or medications. Initial

PATIENT RIGHTS: I have received a copy of the **PRIVACY NOTICE, PATIENT RIGHTS and GRIEVANCE POLICY**. Initial

SENSORY OR PHYSICAL IMPAIRMENTS: I understand **Baylor Medical Center at Uptown** has resources to meet most special needs for patients with sensory or physical impairments. I do / do not have special needs. Initial

Identified needs:

Patient or Legal Guardian Signature Date / / Time

Witness Signature Date / / Time



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Texas law requires healthcare facilities to ask patients to identify their own race and ethnic background. If the patient fails or refuses to identify their own race and ethnic background, facility staff will use its best judgment in making the identification.

Race:

- American Indian, Eskimo or Aleut
- Asian or Pacific Islander
- Black or African American
- White
- Other: (including multi-racial, mixed)
- Prefer Not to Answer

Language:

- English
- Spanish
- Other:

Ethnicity:

- Hispanic
- Non-Hispanic
- Prefer Not to Answer

Patient or Legal Guardian Signature Date / / Time

Witness Signature Date / / Time

Access to Health Records Online

If you would like to have access to your records for this radiology visit online, please provide your email address below. You should receive an email invitation to join **myHealth** from **United Surgical Partners** [\[mailto:noreply@iqhealth.com\]](mailto:noreply@iqhealth.com) Please check your SPAM folder if you don't find it in your inbox.

Patient Satisfaction Survey

We would like you to have a voice in our quality improvement. With your permission, we will email you a survey to allow you to give us feedback about your experience as a patient at **Baylor Medical Center at Uptown**. Your email address will be kept confidential, and not used for any other purpose.

Please enter your email address here:

Disclosure of Physician Ownership

Baylor Medical Center at Uptown meets the Federal definition of a physician-owned hospital, and a list of the hospital's owners that are physicians (or their immediate family members) is available upon request. Radiologists are independent contractors, not owners or employees of **Baylor Medical Center at Uptown**.

Baylor Medical Center at Uptown is committed to providing clinical excellence in a safe, attractive environment for you and your family members. We are proud that many of the physicians who practice here have chosen to have ownership in this hospital. Their ownership enables them to have a voice in the administration and policies of our hospital. This involvement helps to ensure the highest quality of care for you.

If you have any questions concerning this notice, please feel free to ask your physician or the Chief Executive Officer at **Baylor Medical Center at Uptown**.

Informed Consent for MRI Scan With or Without Contrast Injection

PATIENT'S NAME: _____ MEDICAL RECORD NUMBER: _____

To the patient: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is an effort to make you better informed so you may give or withhold your consent to the procedure.

Inform center personnel at once if you are pregnant, or think you may be pregnant.

Inform the technologist if you have heart valves, a pacemaker, aneurysm clips or other implanted metallic or electrical devices.

CONSENT TO IMAGING PROCEDURE: Your attending physician believes it beneficial for you to undergo a diagnostic imaging procedure known as Magnetic Resonance Imaging (MRI) to aid in diagnosing and treating your medical condition. MRI does not use x-rays or radiation. Instead a magnetic field and radio waves are used to create an image of internal body structures. MRI is a painless procedure that requires that you lie still on a padded table that gently glides you into the magnet. As part of your MRI exam, a contrast agent may be injected into your vein in order to produce better images of the part of your body that is being examined. The MRI procedure may be conducted without the injection of the contrast agent, but the images may not be as helpful to the radiologist and your physician. If you wish to refuse the contrast injection, inform the technologist and the MRI will be conducted without the contrast agent.

POTENTIAL RISKS: The following complications are possible anytime an injection is given: potential for pain, bleeding, bruising or swelling at the injection site. MRI exams requiring contrast may result in a mild headache, nausea, itching or other vague symptoms for a short time after the injection. Additional allergic reactions in response to the contrast agent may include hives, shortness of breath or difficulty swallowing. There have been rare instances of death after the administration of the contrast agent. It is very important to inform the technologist if you experience any of the conditions mentioned in this form.

NOTE TO PATIENTS: If you previously had a reaction to a contrast injection such as hives, severe itching, shortness of breath and/or any significant reaction requiring hospitalization, a history of asthma, or other allergic conditions, any history of anemia, sickle cell anemia, or kidney disorder, are pregnant or breast feeding you must inform the technologist. The safety of contrast for children under the age of two has not been established.

PATIENT SIGNATURE: I certify this form has been fully explained to me, that I have read it or have had it read to me, that the blank spaces have been filled in, and that I understand its contents. I have been given an opportunity to ask questions about my condition, alternative forms of treatment, risks of non-treatment, the procedures to be used, and the risks and hazards involved and I believe that I have sufficient information to give this informed consent.

I understand that the physicians participating in my care at BMC@U are not employees or agents of Baylor Medical Center at Uptown Hospital. They are either independent physicians engaged in the private practice of medicine or are licensed physicians participating in the care of patients as part of a post-graduate medical education program. Physicians who may participate in my care in addition to my attending physician include, but are not limited to radiologists, pathologists, anesthesiologists, neonatologists, cardiologists, pulmonologists, gastroenterologists and nephrologists. The physicians participating in my care may or may not be financial partners at Baylor Medical Center at Uptown.

SIGNATURE OF PATIENT OR LEGAL RESPONSIBLE PERSON (STATE RELATIONSHIP) DATE

WITNESS TO SIGNATURE

DATE



NAME: [PatientLast], [PatientFirst]
ACT#: [PatientId] GENDER: [Sex]
DOB: [DOB] AGE: [Age]
DR: [PhyLast], [PhyFirst]
DOS: [DOS]

Patient Name: _____ Date: _____ Sex: M F Weight: _____ DOB _____

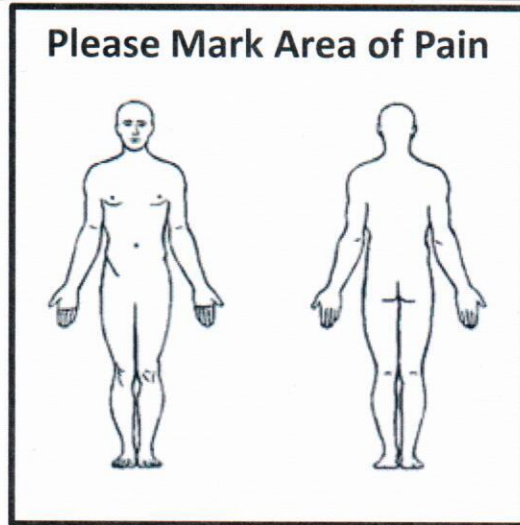
Referring Physician: _____ Reason for your exam (MRI) today: _____

Have you had a previous Imaging relating to this problem? Y N

If yes, what type of exam was done and name of the facility that performed the exam:

Please indicate if you have any of the following:

- Yes No Brain/ Aneurysm clip(s)
- Yes No History of Seizures
- Yes No Cardiac pacemaker
- Yes No Implanted cardioverter defibrillator (ICD)
- Yes No Electronic implant or device
- Yes No Heat dispersion disorders
- Yes No Spinal cord stimulator
- Yes No Internal electrodes or wires
- Yes No Bone growth/bone fusion stimulator
- Yes No Ear/ Cochlea Implant/ Hearing Aid
- 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 Artificial or prosthetic limb
- Yes No Stents/ Filters/ Coils
- Yes No Shunt (spinal or intraventricular)
- Yes No Vascular access port and/or catheter
- Yes No Medication patch (Nicotine, Nitroglycerine)
- Yes No Any metallic fragment or foreign body
- 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 Dentures or partial plates
- Yes No Tattoo or permanent makeup
- Yes No Body piercing jewelry
- Yes No Any other metal objects (gun shots, BB's, shrapnel) or implants _____
- Yes No Breathing problem or motion disorder
- Yes No Claustrophobia



IMPORTANT INSTRUCTIONS

Before entering the MRI scan 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, wigs, hair extensions, coins, pens, pocket knife, nail clipper, tools, clothing with metal fasteners & clothing with metallic threads.

List Previous Surgeries: _____

List All Allergies: _____

List All Medical Problems: _____

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 information on this form.

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

Form Completed By: Patient Relative Nurse (Print name of person completing form) _____

Form Information Reviewed By: _____

MRI Technologist Nurse Radiologist Other _____

Technologist Notes: _____

Revised: 06/19/14



Patient's Communication Preferences Regarding their PHI

Telephone Communication Preferences

Place Patient Identification Label Here

Home # _____

Work # _____

Mobile # _____

E-Mail Communication Preferences

Email Address _____

In order to best serve our patients and communicate regarding their services and financial obligations we will use all methods of communication provided to expedite those needs. By providing the information above I agree that Baylor Medical Center at Uptown or one of its legal agents may use the telephone numbers provided to send me a text notification, call using a pre-recorded/artificial voice message through the use of an automated dialing service or leave a voice message on an answering device. If an email address has been provided, Baylor Medical Center at Uptown or one of its legal agents may contact me with an email notification regarding my care, our services, or my financial obligation.

Mail Communication Preferences

May we send mail to your home address? ***(If no, please provide an alternate mailing address below.)***

Other than you, your Insurance company, and health care providers involved in your care, whom can we talk with about your health care information? (Check all that apply)

| | <u>Name</u> | <u>Telephone</u> |
|------------------------------------|-------------|------------------|
| <input type="checkbox"/> Spouse | _____ | _____ |
| <input type="checkbox"/> Caretaker | _____ | _____ |
| <input type="checkbox"/> Child | _____ | _____ |
| <input type="checkbox"/> Parent | _____ | _____ |

Other _____

Do you have any health information that you would like to be kept confidential from any person or persons? If so, please specifically describe the information and person or persons below:

I acknowledge that I have been given the opportunity to request restrictions on use and/or disclosure of my protected health information.

I acknowledge that I have been given the opportunity to request alternative means of communication of my protected health information.

Patient or Personal Representative Signature

Date

Printed Name

Relationship to Patient

Pregnancy Screening Form

(Ages 12-55 years)

Patient Name: _____ Age: _____

1.) Are you pregnant or do you think you may be pregnant? _____ Y _____ N
(If "yes", please notify staff immediately).

2.) Have you had a hysterectomy or are post-menopausal? _____ Y _____ N
(If "yes", please sign below).

3.) Have you had a menstrual period within the last 30 days? _____ Y _____ N
(If "no", you will need to have a pregnancy test).

4.) Please give the date of the 1st day of your last menstrual period. _____

5.) Does this date fall within the last 10 days? _____ Y _____ N
(If "yes", please sign below).

6.) Are you currently practicing any of the following birth control? _____ Y _____ N

- A.) Tubal Ligation _____
- B.) Partner Vasectomy _____
- C.) Oral Contraceptives _____
- D.) Condom _____
- E.) Diaphragm _____
- F.) Foam _____
- G.) IUD _____
- H.) Other _____

7.) If you are NOT practicing any birth control measures, have you had sexual activity since your last menstrual period that may put you at risk of pregnancy? _____ Y _____ N

I have stated that I am NOT pregnant and request the ordered Imaging procedure be performed.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____