



Patient Registration Form (PLEASE PRINT)

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 ___ Chinese ___

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: (____) _____

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: _____

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: _____

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 ProScan 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 ProScan 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 ProScan 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 ProScan 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)

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.

CONTINUED ON BACK

Informed Consent for Ultrasound

CONTINUED

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 ProScan of my current medical condition and have complied with any requirements 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 ProScan 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



HIPAA Acknowledgment & Office Policies

BY SIGNING BELOW, I HEREBY ACKNOWLEDGE AND AGREE TO THE FOLLOWING POLICIES:

RESPONSIBILITY FOR VALUABLES. ProScan does not assume responsibility for securing any and all valuables and personal items belonging to patients or visitors. You are responsible for securing all valuables or personal items prior to your imaging exam.

**I have read and understand the above statements and acknowledge that ProScan and its employees are not liable for the loss or theft of my valuables or personal items.*

CHILDREN IN THE WAITING ROOM. ProScan is not responsible for providing supervision of any child during your imaging exam. You are welcome to bring your child or children if there is another adult accompanying you to supervise your child or children while your imaging exam is being done.

**I have read and understand the above statements and acknowledge that ProScan and its employees will not be responsible for providing childcare for my child or children during my imaging exam.*

CANCELLATION POLICY. If you will not be able to appear for your scheduled appointment, you must notify ProScan 24 hours prior to your appointment time. If you miss or cancel your appointment without giving the appropriate 24-hour notice, ProScan may charge you a \$50.00 cancellation fee.

**I have read and understand the above statements and acknowledge that if I do not provide ProScan with 24 hours prior notice that I cannot keep my scheduled appointment, I may be charged a \$50.00 cancellation fee.*

BY SIGNING THIS DOCUMENT BELOW, I HEREBY ACKNOWLEDGE THAT I HAVE BEEN OFFERED AND/OR HAVE RECEIVED A COPY OF PROSCAN IMAGING AND AFFILIATED ENTITIES NOTICE OF PRIVACY PRACTICES.

I hereby give my consent for ProScan Imaging and Affiliated Entities to release my protected health information to the following individual(s): *(PLEASE PRINT)*

_____	Relationship to Patient _____
_____	Relationship to Patient _____
_____	Relationship to Patient _____

FOR PROSCAN IMAGING USE ONLY – RECEIPT OF NOTICE OF PRIVACY PRACTICES ONLY

Date Acknowledgment Received: _____ Initials: _____

-OR-

Reason Acknowledgment was not obtained: _____

Patient or Legal Representative Signature

Date: _____

Print Name

Relationship/Authority if Legal Representative



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