ADVANCED MRI AND IMAGING

2821 US HWY 27 North • Sebring, FL 33870
Phone: (863) 385-8000 • Fax: (863) 385-8002

Diagnostic Study Registration Form

Patient Name _____Date_____

Date of Birth _____Age _____Weight _____Height_____Sex: ___Male _____Female

HOME ADDRESS _____

MAILING ADDRESS_____

PRIMARY CARE PHYSICIAN_____

Patient Home Ph _____Patient Cell Phone _____Email_____

AREA TO BE EXAMINED / TYPE OF EXAMINATION:_____

DIAGNOSIS OR CLINICAL SUSPICION_____

Have you had any previous X-Rays, MRIs, CTs, DEXA or Ultrasounds? _____ Yes _____No

If yes: What _____When _____Where_____

Have you ever smoked? If yes for how long?_____ How many packs a day?_____ If you are an ex-smoker, how long ago did you quit? _____

Cancer _____Yes _____No

If yes: What type _____Body Part _____

Radiation therapy: _____Yes _____No Chemotherapy: _____Yes___ No____

Are you **pregnant**? _____Yes _____No Date of last menstrual period:_____

Patient or Legal Representative Signature: _____ Date:_____

Witness or Interpreter Signature :_____ Date:_____

Technologist Signature: _____ Date:_____

Additional comments:_____

_____

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By signing this form, you are granting consent to Advanced MRI and Imaging to use and disclose your protected health information for the purpose of treatment ,payment, and health care operations as well as any ordered testing or imaging.

Our notice of privacy practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our notice of privacy practices before you sign this consent.

Our notice of privacy practices is subject to change. If we change our notice , you may obtain a copy of the revised notice from our office.

You have the right to request us to restrict how we use and disclose your protected health information for the purpose of treatment, payment , or health care operations. We are not required by law to grant your request. However , if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing , except to the extent we already have used or disclosed your protected health information in reliance on your original consent.

X _____

Patient Name (Please Sign)

_____

(Date)

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize the physician/staff of Advanced MRI and Imaging to send artificial, prerecorded, or automated calls and text messages and to release/leave medical information, with the following (please check applicable):

_____ Spouse

_____ Significant other

_____ Family Member (name: _____)

_____ Caregiver

_____ Answering Machine

_____ Send artificial, prerecorded, or automated calls and test messages.

I understand and acknowledge that should I need to change how I receive my medical information or messages that it will be necessary to notify my provider/office to those changes.

X _____

Signature of Patient (of parent/guardian or minor) Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

FOR OFFICE USE ONLY

Print Name: _____

Signature: _____ Date: _____

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Advance MRI & Imaging is committed to the health and safety of all our patients, visitors and team members. We are conducting screening for COVID-19. If you answer yes to any of the questions below, you will be given further instructions.

We now require all patients to be wearing a mask at all times during your visit to the center.

1. Do you currently have a cough, fever, shortness of breath or difficulity breathing? **YES / NO**
2. Have you travelled outside highlands county within the past 14 days? **YES / NO**
3. **If yes where?**
4. Have you had close contact with someone with known or suspected COVID-19 in the last 14 days? **YES / NO**
5. Have you been tested for COVID-1`9 within the past 14 days? **YES / NO**

   If YES: When_____ What were the results?_____

Patient signature