

**I CONSENT (AGREE) TO MEDICAL SERVICES:** I, the undersigned, hereby agree and consent to the plan of care proposed to me by the service practitioner to whom I have been referred. I will ask for any information I want to have about my services and will make my wishes known to the practitioners and/or staff. I understand that First Hill Diagnostic Imaging, also known as Swedish/First Hill Imaging, LLC, is a joint venture of Swedish Health Services and Imaging Services, Inc.

**IN CASE OF AN EMERGENCY I WILL BE TREATED, INCLUDING CARDIOPULMONARY RESUSCITATION (CPR) UNLESS I REFUSE:** This is to inform you of First Hill Diagnostic Imaging's (FHDI) policy in the event you should have an unexpected medical emergency. Our policy is to call 911 for medical assistance.

**FHDI IS NOT RESPONSIBLE FOR MY PERSONAL VALUABLES:** FHDI shall not be liable for the loss or damage to any money or articles of value such as eye glasses, watches and jewelry.

**FHDI MAY GIVE INFORMATION TO MY HEALTH INSURANCE COMPANY FOR PAYMENT:** FHDI to the extent required to assure payment, will disclose any diagnosis and pertinent medical information to a designated person, corporation, governmental agency or third party payor which is liable to FHDI for charges or who may be responsible for determining the necessity, appropriateness, or amount related to FHDI services or charges, including medical service companies, insurance companies, workmen's compensation carriers, Social Security Administration, intermediaries, carriers, and the State Department of Health and Human Services when the patient is a Medicaid or Medicare recipient. I understand that this disclosure, unless expressly limited by me in writing will extend to all aspects of my medical care including testing and or treatment for HIV/AIDS, sexually transmitted diseases, substance abuse, or mental health conditions.

**IT IS MY RESPONSIBILITY TO PAY MY BILL OR TO MAKE ARRANGEMENTS TO HAVE MY BILL PAID:**

**Private Pay:** The undersigned agrees, whether signing as agent or as a patient, to be financially responsible to FHDI for charges not paid by insurance. I understand this amount is due upon billing.

**Insurance Coverage:** I certify that the information given to me in applying for payment under government or private insurance is correct. I hereby assign payment directly to First Hill Diagnostic Imaging for benefits otherwise payable to me. Any portion of charges not paid by the insurance company will be billed to me and is then due and payable upon billing. I understand FHDI may verify my insurance coverage but that this does not guarantee payment by the insurance company and I will be responsible for all non-covered charges. I understand that it is my sole responsibility to determine the coverage limits of my insurance.

**Financial Assistance:** FHDI offers financial assistance for services that are provided in FHDI. Information and applications are available to you prior to or at any point during your service or after you have received a bill from us. Please contact a registration representative for further details.

**I HAVE RECEIVED THE NOTICE OF HEALTH INFORMATION PRACTICES:** I have received a copy of FHDI's Notice of Health Information Practices, which provides information about how my health information may be used and disclosed. I have read the above and understand its contents.

I have read the above and understand its contents.

Date: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Patient's Agent or Representative Signature: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

PATIENT LABEL/TECH NOTES

**FIRST HILL DIAGNOSTIC IMAGING**  
**A Swedish Medical Imaging Center**

Form 71004 Nonstock Rev. 4/09 CC

**CONSENT FOR MEDICAL SERVICES**

# PATIENT REGISTRATION

**PLEASE PRINT**

<b>Next Appointment with your doctor:</b>	
Date: _____	Time:   :   am/pm

<b>Referring Doctor Name (last, first):</b> _____
---

<b>PATIENT</b>	Name: _____	Home Address: _____	
	Sex: <input type="checkbox"/> M <input type="checkbox"/> F   Marital Status: S___ M___ D___ W___ (	City/State: _____	Zip: _____
	Date of Birth:     /     /     SS#: -	Phone: (     )     _____	Country: _____

<b>EMPLOYER</b>	Company: _____	<b>EMERGENCY</b>	Name: _____
	Address: _____		Address: _____
	City/State: _____ Zip: _____		City/State: _____ Zip: _____
	Work Phone: (     ) _____		Phone: (     ) _____
	Occupation: _____ <input type="checkbox"/> FT <input type="checkbox"/> PT   Stu		Relation to Patient: _____

<b>PERSON RESPONSIBLE FOR BILL</b>	Patient's Relationship to Guarantor: _____	Employer: _____
	Name: _____	Address: _____
	Address: _____	City/State: _____ Zip: _____
	City/State: _____ Zip: _____	Work Phone: (     ) _____
	Home Phone: (     ) _____	Occupation: _____

<b>PRIMARY INSURANCE</b>	<i><b>Please provide copy of insurance card</b></i>	
	Name of insurance company: _____	ID/Certificate #: _____
	Address: _____	Policy/Group #: _____
	City/State: _____ Zip: _____	Group Name: _____
	Patient's Relationship to Subscriber: _____	Authorization #: _____
	Subscriber Last:                      First:                      M.I Birth Date:     /     /     SS#:     -     -	

<b>SECONDARY INSURANCE</b>	<i><b>Please provide copy of insurance card</b></i>	
	Name of insurance company: _____	ID/Certificate #: _____
	Address: _____	Policy/Group #: _____
	City/State: _____ Zip: _____	Group Name: _____
	Patient's Relationship to Subscriber: _____	Authorization #: _____
	Subscriber Last:                      First                      M.I Birth Date:     /     /     SS#:     -     -	

<b>INJURY</b>	Injury? <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>ATTORNEY</b>	Is an attorney involved? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Work related? <input type="checkbox"/> Yes <input type="checkbox"/> No		Attorney name: _____ Phone: (     ) _____
	Auto accident? <input type="checkbox"/> Yes <input type="checkbox"/> No		Address: _____
	Injury date:            /     /		City/State: _____ Zip: _____

As patient or legal guardian of patient, I agree to pay for all services rendered within 30 days of service in accordance with the financial policy of this office. I understand that this office bills insurance as a courtesy and that payment of the charges is my responsibility. I authorize my insurance benefits to be paid directly to the doctor & authorize the doctor or my insurance company to release any required information on this claim.

SIGNED: \_\_\_\_\_ DATE: \_\_\_\_\_

## FIRST HILL DIAGNOSTIC IMAGING

A Swedish Medical Imaging Center

## BSGI PATIENT QUESTIONNAIRE

Name \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_ Today's Date \_\_\_\_\_

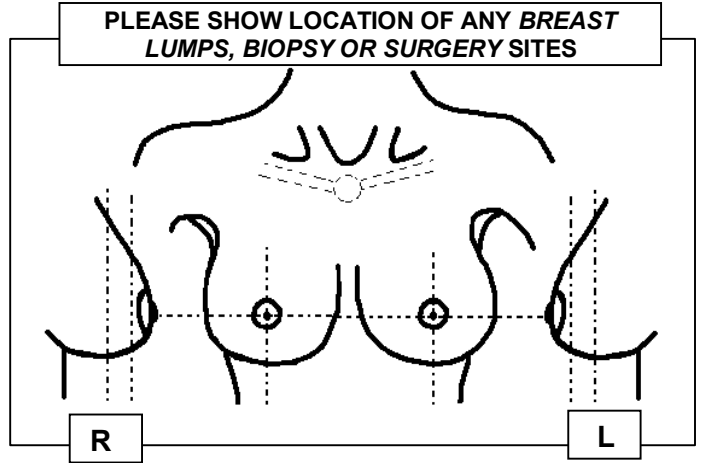
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Home/Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Referring Doctor \_\_\_\_\_

**Reason for today's visit?** \_\_\_\_\_

**Current Breast Concerns – Please Describe and Draw Location:**

- |   |                                      |                                       |
|---|--------------------------------------|---------------------------------------|
| <input type="checkbox"/> Lumps                  | <input type="checkbox"/> Left Breast | <input type="checkbox"/> Right Breast |
| <input type="checkbox"/> Pain                   | <input type="checkbox"/> Left Breast | <input type="checkbox"/> Right Breast |
| <input type="checkbox"/> Nipple Discharge       | <input type="checkbox"/> Left Breast | <input type="checkbox"/> Right Breast |
| <input type="checkbox"/> Trauma in last 4 years | <input type="checkbox"/> Left Breast | <input type="checkbox"/> Right Breast |
| <input type="checkbox"/> Other Problems         | Describe _____                       |                                       |



**Recent Mammogram:** When \_\_\_\_\_ Where \_\_\_\_\_

**Ultrasound Exam:** When \_\_\_\_\_ Where \_\_\_\_\_

**MRI Exam:** When \_\_\_\_\_ Where \_\_\_\_\_

**BSGI Exam:** When \_\_\_\_\_ Where \_\_\_\_\_

**Family or Personal History of Breast Cancer:** \_\_\_\_\_

Age at 1<sup>st</sup> Period \_\_\_\_\_ Age at 1<sup>st</sup> pregnancy \_\_\_\_\_ Age at Menopause \_\_\_\_\_

Are you taking Birth Control/Hormones/Estrogen?  Yes  No Started \_\_\_\_\_ Stopped \_\_\_\_\_

**Surgical Procedures/History** (please draw on diagram above)

- |  |                                      |                                       |            |
|--|--------------------------------------|---------------------------------------|------------|
| <input type="checkbox"/> Needle Biopsy           | <input type="checkbox"/> Left Breast | <input type="checkbox"/> Right Breast | Date _____ |
| <input type="checkbox"/> Surgical Biopsy         | <input type="checkbox"/> Left Breast | <input type="checkbox"/> Right Breast | Date _____ |
| <input type="checkbox"/> Lumpectomy (for cancer) | <input type="checkbox"/> Left Breast | <input type="checkbox"/> Right Breast | Date _____ |
| <input type="checkbox"/> Radiation               | <input type="checkbox"/> Left Breast | <input type="checkbox"/> Right Breast | Date _____ |
| <input type="checkbox"/> Mastectomy              | <input type="checkbox"/> Left Breast | <input type="checkbox"/> Right Breast | Date _____ |
| <input type="checkbox"/> Implants                | <input type="checkbox"/> Left Breast | <input type="checkbox"/> Right Breast | Date _____ |
| <input type="checkbox"/> Breast Reduction        | <input type="checkbox"/> Left Breast | <input type="checkbox"/> Right Breast | Date _____ |
| <input type="checkbox"/> Cysts or other problems | Describe _____                       |                                       |            |

Are you currently **pregnant** or have reason to believe you may be pregnant?  Yes  No

Patient Signature \_\_\_\_\_ Date of Last Menses \_\_\_\_\_

**Technologist Evaluation**

Sestamibi Tc99 Dose \_\_\_\_\_ mCi

Site of Injection: \_\_\_\_\_ :

Time of Injection: \_\_\_\_\_ am / pm

Tech's Initials \_\_\_\_\_

Comments: \_\_\_\_\_