

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

Next Appointment with your doctor: Date: _____ Time: _____ : am/pm	Referring Doctor Name (last, first): _____
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PATIENT	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: _____

EMPLOYER	Company: _____	EMERGENCY	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: _____

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

PRIMARY INSURANCE	<i>Please provide copy of insurance card</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#: - -

SECONDARY INSURANCE	<i>Please provide copy of insurance card</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#: - -

INJURY	Injury? <input type="checkbox"/> Yes <input type="checkbox"/> No	ATTORNEY	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

MAGNETIC RESONANCE SCREENING

Because of the presence of a strong magnetic field, it is important that we are aware of any metallic objects that have been surgically placed in the body. Therefore, an accurate surgical and medical history is needed.

When is your follow up appointment with your doctor? _____ What is your weight and height? _____

Have you ever had dialysis? Yes No Do you have a history of liver disease or liver transplant? Yes No

Do you have any of the following? Check all that apply:

Kidney disease Sickle cell anemia Heart disease Multiple myeloma High blood pressure
 Multiple sclerosis Advanced congestive heart failure (CHF) Diabetes

Are you on any medication your doctor has told you could affect your kidney function? Yes No

Have you been treated with any chemotherapy agents? Yes No Are you on IV antibiotics? Yes No

Do you have medication allergies? If yes, please list: _____

Do you have a known allergy to MRI contrast (gadolinium)? Yes No

Have you had MRI contrast (gadolinium) administered before? Yes No If yes, was it within the last 48 hours? Yes No

Please check if you have any of the following:

Cardiac Pacemaker	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Implanted Cardiac Defibrillator	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart Valve Replacement	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart Bypass Surgery	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Stent Placement	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Aneurysm or Aortic Clip/Coils	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Neurostimulator	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Implanted Pumps	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Carotid Sinus Stimulation Device	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Shunt	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Deep Brain Stimulator	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Vagus Nerve Stimulator	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Occular (eye) Implant	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cochlear (ear) Implant	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hearing Aids	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Joint Replacements	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Artificial Limbs	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Wire Sutures	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Harrington Rods	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fractured Bones treated with screws, pins, or any metal	<input type="checkbox"/> Yes	<input type="checkbox"/> No
IVC Filter	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Swan-Ganz or Thermodilution Catheter	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Temperature Sensing Foley Catheter	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Tattoo/Cosmetic tattoo? Yes No

Have you had a tattoo removed? Yes No

Medication Patches or Dressings containing Silver Yes No

Are you wearing creams/lotions containing silver? Yes No

Any other metal implants? Yes No

History of Cancer? Yes No

History of Tumor? Yes No

Removable Dental Work Yes No

Body Piercings Yes No

Shrapnel/bullet fragments Yes No

Have you ever grinded/welded with metal or had metal in eyes? Yes No

For men only:

Penile Implant Yes No

Prostate Seeds Yes No

For Women only:

Are you pregnant? Yes No

Are you breast feeding? Yes No

IUD Yes No

Breast Tissue Expander/Pump Yes No

Have you ever had surgery on the part of the body we will be examining? If yes, please explain:

Have you had prior imaging studies of the body part we are imaging today? (X-ray, CT, MRI)

If yes, kind of study: _____ where? _____ when? _____

Signature _____ Date _____

Name of person filling out this form if other than patient (please print) _____

Relationship to patient (please print) _____

PATIENT LABEL

FIRST HILL DIAGNOSTIC IMAGING

A Swedish Medical Imaging Center

SEATTLE, WASHINGTON

Form 70993 Nonstock Rev. 3/12/10 CC

MAGNETIC RESONANCE SCREENING

CONTRAST-ENHANCED BREAST MR: PATIENT INFORMATION

Dear Patient,

We have been asked to do a magnetic resonance (MR) imaging exam of your breasts. This study is usually done for a breast lump or mammographic finding, to define the extent of a known tumor, or because of personal or family risk factors for cancer.

Breast MR has been done at First Hill Diagnostic Imaging since 1992. The First Hill physicians are internationally recognized in advanced breast imaging.

This letter informs you of some of the advantages and limitations of this exam.

Advantages and Limitations:

Breast MR can usually detect breast cancers down to about 4 - 5 mm in diameter (the size of a pea), even when mammograms or physical exam are normal; however, tumors smaller than 4 mm can be missed. Rarely, larger cancers which do not take up the MR contrast material may not be detected. Also, some benign breast disorders may look like cancer, and may then require ultrasound or biopsy for final diagnosis.

Some forms of noninvasive breast disorders, for example ductal carcinoma *in situ* (DCIS) or lobular carcinoma *in situ* (LCIS) may not be detected by MR, but may be seen on mammograms or on the pathology slides from a biopsy or surgery. Therefore, mammograms remain very important for diagnosis.

MR of the breast, when used together with mammography, can help to significantly improve breast cancer diagnosis. As a result, insurance coverage for cancer-related breast MR has been generally favorable.

This exam also looks at the lymph nodes under your arm and some nodes that appear normal on MR, may contain tumor when examined by the pathologist's microscope. High-resolution ultrasound is frequently done after the MR to check questionable areas seen only on the MR exam, even if you have had a prior ultrasound.

Your signature indicates that you have been informed of some of the potential limitations of breast MR. If you have any questions or reservations, please ask us. We will gladly answer your questions.

Sincerely,

Bruce A. Porter MD, FACR

Medical Director

Patient signature

Date

Please Print Your Name

FIRST HILL DIAGNOSTIC IMAGING

A Swedish Medical Imaging Center

Form 77744 Nonstock Rev. 1/10 CC

US/MR BREAST QUESTIONNAIRE

Your name: _____ Birth date: ____/____/____

Your primary physician: _____ Surgeon: _____

Reason for exam:

- KNOWN BREAST CANCER RIGHT LEFT
- NIPPLE DISCHARGE RIGHT LEFT
- BREAST LUMP RIGHT LEFT
- IMPLANTS SILICONE SALINE
- PERSONAL HISTORY OF BREAST CANCER
- HIGH RISK/FAMILY HISTORY
- ENLARGED LYMPH GLANDS UNDER ARM
- OTHER: _____

Previous mammogram:

YES NO DATE: _____ WHERE?: _____

Previous breast surgery? Yes No

RIGHT: Benign Malignant DATE: ____/____/____
MO. YEAR

LEFT: Benign Malignant DATE: ____/____/____
MO. YEAR

Previous breast biopsies? Yes No **NEEDLE ?:** _____ **SURGICAL?:** _____

RIGHT LEFT DATE: ____/____/____
MO. YEAR

Are you breast feeding? Yes No

Are you having menstrual periods? Yes No

If yes, first day of last menstrual period ____/____/____

Usual # of days from one period to the next _____

Have you taken birth control pills, hormone replacement therapy, naturopathic or bioidentical hormones in the last six months? Yes No

If yes, are you presently taking them? Yes No

If no, when did you discontinue use? ____/____/____

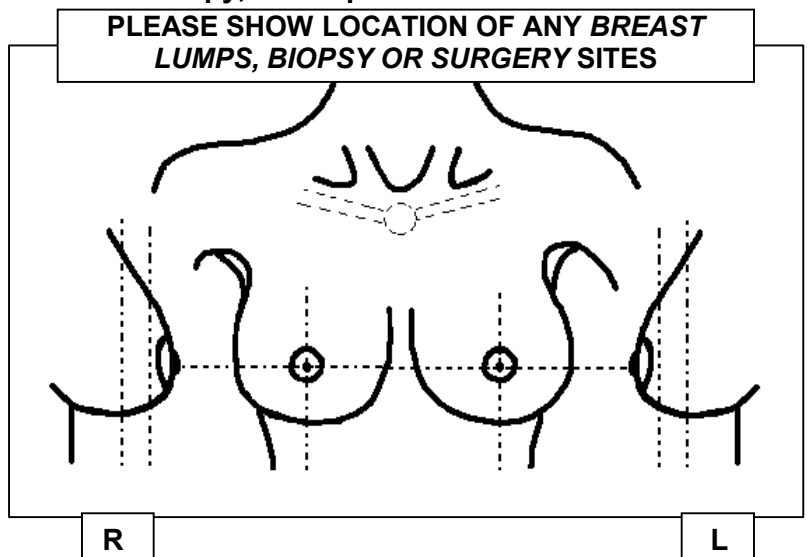
Family history of breast cancer?

**if you know, please note age at diagnosis*

- MOTHER/AGE: _____
- AUNT/AGE: _____
- SISTER/AGE: _____
- GRANDMOTHER/AGE: _____

Next appointment with your physician or surgeon?

_____/_____/_____



FIRST HILL DIAGNOSTIC IMAGING

A Swedish Medical Imaging Center

Form 77742 Nonstock Rev. 11/5/09 CC