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):

PATIENT

Name:
Home Address:
Sex: ☐ M ☐ F Marital Status: S___ M___ D___ W___ (
City/State: Zip:
Date of Birth: / / SS#: –
Phone: ( ) Country:

EMPLOYER

Company:
Address:
City/State: Zip:
Work Phone: ( )
Occupation: ☐ FT ☐ PT Stu

EMERGENCY

Name:
Address:
City/State: Zip:
Phone: ( )
Relation to Patient:

PERSON RESPONSIBLE FOR BILL

Patient's Relationship to Guarantor:
Name:
Address:
City/State: Zip:
Home Phone: ( )

Employer:
Address:
City/State: Zip:
Work Phone: ( )
Occupation:

PRIMARY INSURANCE

Please provide copy of insurance card

Name of insurance company:
Address:
City/State: Zip:
Patient's Relationship to Subscriber:
Subscriber Last: First: M.I

ID/Certificate #:
Policy/Group #:
Group Name:
Authorization #:
Birth Date: / / SS#: – –

SECONDARY INSURANCE

Please provide copy of insurance card

Name of insurance company:
Address:
City/State: Zip:
Patient's Relationship to Subscriber:
Subscriber Last: First M.I

ID/Certificate #:
Policy/Group #:
Group Name:
Authorization #:
Birth Date: / / SS#: – –

INJURY

Injury? ☐ Yes ☐ No
Work related? ☐ Yes ☐ No
Auto accident? ☐ Yes ☐ No
Injury date: / /

ATTORNEY

Is an attorney involved? ☐ Yes ☐ No
Attorney name: Phone: ( )
Address:
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

Form 77736 N.S. 1/10 CC

PATIENT HISTORY FORM

Name: ____ DOB: _____________ Male ☐ Female ☐
Last First Middle Initial

1. Please list the part of your body that will be scanned today:
____
2. What are your current symptoms or reason your doctor ordered the exam?
____
3. Location of symptoms (explain & mark on diagram below): ____
4. Pain? Yes ☐ No ☐ Where?: ____
5. Any relevant prior injuries? Yes ☐ No ☐ When?: ____

   Describe: ____
6. Any relevant prior surgeries or radiation therapy? Yes ☐ No ☐ When?:___________________________

   Describe: ____
7. Have you had related imaging studies (i.e., *MR, CT, Ultrasound, X-ray, etc.*)? Yes ☐ No ☐

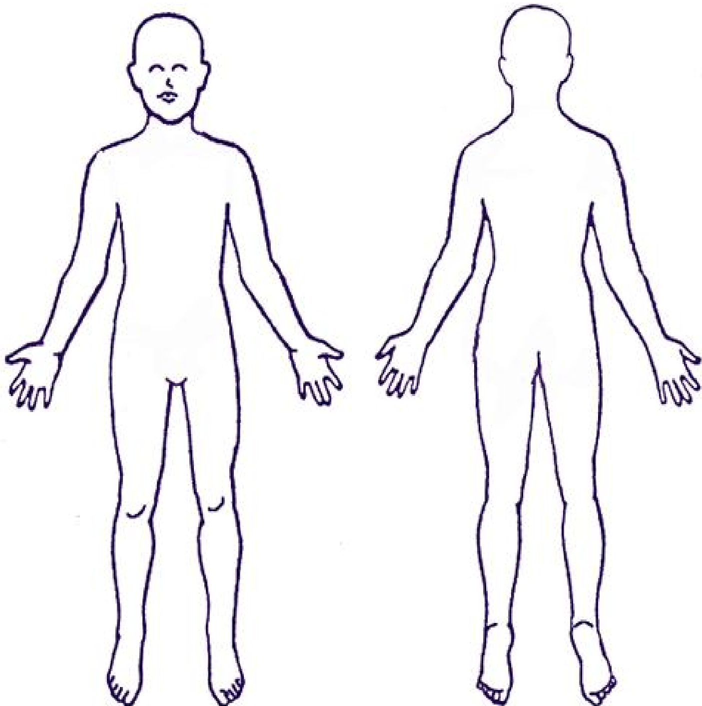
   Type of study: ___________________ Where? ______________________ When? __________________

   Type of study: ___________________ Where? ______________________ When? __________________
8. Is there is any other related medical history we should know:

   Describe: ____

   ____
9. Do you need a CD of your images? Yes ☐ No ☐

Signed: ____ Date:____________________
Signature of patient or other person completing form



TECH/PHYSICIAN NOTES:

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:

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

Item	Yes	No
Tattoo/Cosmetic tatto?	☐ 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

MR CONTRAST SCREENING FORM

1. **Have you had MRI contrast or gadolinium administered before? Yes ☐ No ☐**

   If yes, was it within the last 48 hours? Yes ☐ No ☐

2. **Do you have a known allergy to gadolinium or MRI contrast material? Yes ☐ No ☐**

   If yes, describe your reaction: ____

3. **Do you have any kidney disease? Yes ☐ No ☐** Describe: ____________________________________

   ____

   If yes, are you on dialysis? Yes ☐ No ☐

4. **Do you have any of the following? Check all that apply.**

   ☐ Diabetes ☐ Multiple Myeloma ☐ Sickle Cell Disease ☐ Advanced Congestive Heart Failure (CHF)

5. **Are you on any medications your doctor has told you could affect your kidney function (e.g., Aminoglycosides, Cyclosporine, Lithium)? Yes ☐ No ☐**

6. **Have you been treated with any of these chemotherapy agents: Amphotericin B, Cisplatin, Carboplatin? Yes ☐ No ☐**

Signed: ____ **Date:** ______________________

Signature of patient or other person completing form

Techs Notes: ____

____

Creatinine: _______ Date: ____________ CrCl:______________

Contrast type: ___________________ Amount: ______________

Pt Name: _________________________

MRN: ___________________________

FIRST HILL DIAGNOSTIC IMAGING

A Swedish Medical Imaging Center

Form 77737 Nonstock Rev. 1/10 CC