

**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> _____
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<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

# 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,<br>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

# 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? \_\_\_\_/\_\_\_\_/\_\_\_\_

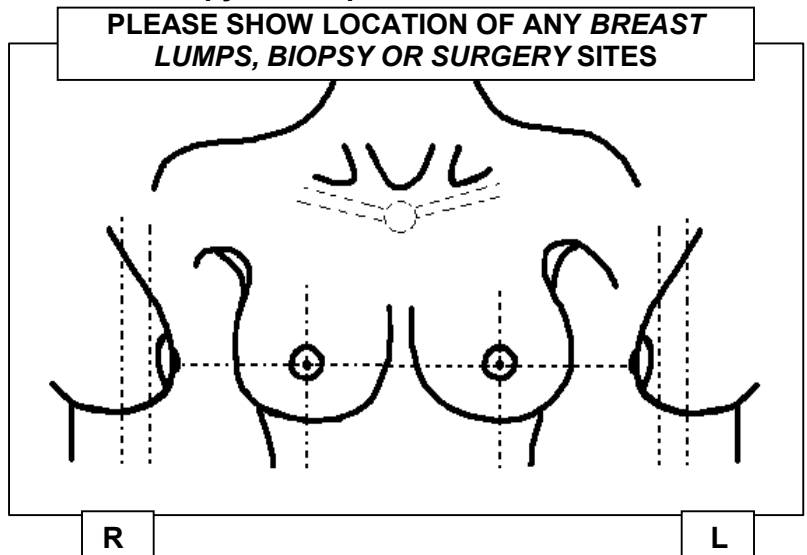
### Family history of breast cancer?

*\*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

## SILICONE BREAST IMPLANT QUESTIONNAIRE

Name: \_\_\_\_\_

(Other LAST NAMES since implants FIRST placed? \_\_\_\_\_)

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Referring Physician: \_\_\_\_\_

### IMPLANT HISTORY:

Please complete for all current and prior implants. Please enter pertinent information for each set of implants in the column for that set of implants, if known. If unknown, put N/A.

### CLINICAL HISTORY:

Please enter a number for both LEFT and RIGHT  
(0 = none, 1 = mild, 2 = moderate, 3 = severe)

Change in Shape	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Left <input type="checkbox"/>	Right <input type="checkbox"/>
Breast Hardness	Left <input type="checkbox"/>	Right <input type="checkbox"/>		
Breast Pain	Left <input type="checkbox"/>	Right <input type="checkbox"/>		
Skin Nodules (lumps) (under the arms or in the breasts)	Left <input type="checkbox"/>	Right <input type="checkbox"/>		

If you have implants in now, have you had an **OPEN** CAPSULOTOMY (surgical) for current implants? Yes  No  Don't Know

LEFT side?   
RIGHT side?

If you have implants in now, have you had a **CLOSED** CAPSULOTOMY for current implants? Yes  No  Don't Know

LEFT side?   
RIGHT side?

(a closed capsulotomy is an office procedure during which the breast is forcefully massaged to soften the scar capsule that surrounds the implant)

If you have implants in now, have either of your current implants suffered TRAUMA? Yes  No  Don't Know

If so, which one(s) \_\_\_\_\_ when \_\_\_\_\_

and how \_\_\_\_\_

**Please note: This exam is designed to evaluate your implants; it is NOT used to diagnose or rule out breast cancer since contrast injections are not used.**

**FIRST HILL DIAGNOSTIC IMAGING**

**A Swedish Medical Imaging Center**

Form 77739 Nonstock Rev. 1/10 CC

## SILICONE BREAST IMPLANT QUESTIONNAIRE (continued)

Reason for initial implant placement:  cosmetic  cancer (mastectomy)

Plan at this time: (fill in number from list below) \_\_\_\_\_

1. definitely leave implants in
2. undecided
3. definitely remove implants, date and surgeon not yet chosen
4. remove implants (if so, Date \_\_\_\_\_ Time \_\_\_\_\_ Surgeon \_\_\_\_\_)

Since your (first) implant(s) were placed,

Have you had any MAMMOGRAMS? Yes  No

Have you had any breast ULTRASOUND examinations? Yes  No

Have you had any breast MRI scans? Yes  No

If so, where? \_\_\_\_\_

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### CURRENT IMPLANTS:

- 0 = no implants in place at this time (removed)
- 1 = single lumen, silicone gel
- 2 = double lumen, silicone gel inner cavity, saline outer cavity
- 3 = double lumen, silicone gel outer cavity, saline inner cavity
- 4 = saline implants

Names of some manufacturers:

<b>Dow Corning</b>	<b>Surgitek</b>	<b>Bioplasty</b>	<b>3M</b>	<b>Cox Uphoff</b>	<b>McGhan</b>
<b>Heyer Schulte</b>		<b>3M/McGhan</b>	<b>Natural Y</b>	<b>Mentor</b>	<b>Baxter Travenol</b>

First Set

Second Set (if applicable)

Manufacturer \_\_\_\_\_ \_\_\_\_\_

Style or Type \_\_\_\_\_ \_\_\_\_\_

Date Placed \_\_\_\_\_ \_\_\_\_\_

Date Removed \_\_\_\_\_ \_\_\_\_\_

Reason Removed \_\_\_\_\_ \_\_\_\_\_

Known Rupture? Yes  No  Yes  No

Known Leak? Yes  No  Yes  No

Textured or Smooth? \_\_\_\_\_ \_\_\_\_\_

Placed Under Muscle? Yes  No  Yes  No

**FIRST HILL DIAGNOSTIC IMAGING**

**A Swedish Medical Imaging Center**