

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.

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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: <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: _____

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ULTRASOUND ABDOMEN QUESTIONNAIRE

Name: _____ DOB: ___/___/___ Today's Date: ___/___/___
please print clearly

Height: _____ Feet _____ Inches Weight: _____ lbs. Male Female

Provider Name: _____ Next appt with provider: _____

Have you been to this facility before? Yes No What year? _____ Same name? Yes No

If NO, under what name:

Exam Requested: Abdomen Aorta Gall Bladder Kidneys Liver Pancreas Spleen

Briefly describe your symptoms and duration:

If you have had prior related exams including abdominal or pelvic biopsies we would like to get copies of those reports and possibly the images for comparison. Please provide the following information: **name of exam, medical facility, year performed and your name at that time if different from today:**

Ultrasound:

CAT scan:

MRI:

X-ray:

Other:

Abdominal or Pelvic Surgeries or other medical procedures (include year):

List any medication(s) you are currently taking:

Previous medical conditions (Check all that apply):

- | | |
|--|--|
| <input type="checkbox"/> Aortic Aneurysm | <input type="checkbox"/> Irritable Bowel Syndrome |
| <input type="checkbox"/> Cancer _____ Yr _____ | <input type="checkbox"/> Kidney Stones |
| <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Organ Transplant _____ Yr _____ |
| <input type="checkbox"/> Gall Stones or Gall Bladder Disease | <input type="checkbox"/> Pancreatitis |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Hernia | <input type="checkbox"/> Vascular Disease |
| <input type="checkbox"/> HIV+ | |

Do you have any chronic medical problems not listed above?

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