Life Sciences PARTNERS

Patient Information Sheet

Section 1: Please fill out all of the following information — for all patients.

_____ _____/_____/_____
Patient Name Date of Birth

_____ _____
Social Security Number Phone Number

_____
Address

_____ _____ _____
City State Zip

_____ _____ _____
E-mail Address Height Weight

Have you ever been here before? ☐ Yes ☐ No If so, when? _____/_____/_____

If your exam requires dietary restrictions, have you had anything to eat/drink in 4-6 hours? ☐ Yes ☐ No

Is this exam related to an injury? ☐ Yes ☐ No If yes, please specify: ☐ WC ☐ Auto

_____ _____/_____/_____
Claim Number Date of Injury

When do you follow up with your referring physician? _____

Section 2: Please fill out all of the following information — for insurance & attorney infomation.

_____ _____
Insurance Company Policy Holder

_____ _____/_____/_____
Relationship to Policy Holder Policy Holder Date of Birth

_____ _____
Name of Attorney Attorney Phone Number

Section 3: Please fill out all of the following information.

_____ _____
Employer Phone Number

_____
Work Address

Life Sciences PARTNERS

Safety Questionnaire Form

1. Do you have any of the following:

Heart Pacemaker	☐ Yes	☐ No
Heart Defibrillator	☐ Yes	☐ No
Brain Aneurysm Clips	☐ Yes	☐ No
Coil, Filter, Stents	☐ Yes	☐ No
Cochlear (Ear) Implant	☐ Yes	☐ No
Injury from Metal Object in Eyes	☐ Yes	☐ No
If you selected YES to METAL INJURY TO EYES, do you seek medical treatment?	☐ Yes	☐ No

STOP!** If you have selected **YES** to any of the above questions, please inform MRI personnel **IMMEDIATELY!

2. Do you have any of the following:

Artificial Heart Valve	☐ Yes	☐ No
Artificial Eyes	☐ Yes	☐ No
Eyelid Spring	☐ Yes	☐ No
Metallic Objects (Shrapnel, Bullet)	☐ Yes	☐ No
Neruo/Biostimulator	☐ Yes	☐ No
Artificial Limbs/Joints	☐ Yes	☐ No
Implants (Pins, Screws, Rods, etc.)	☐ Yes	☐ No
Internal Electrodes or Wires	☐ Yes	☐ No
Tattoos/Tattooed Makeup	☐ Yes	☐ No
Diaphragm/IUD	☐ Yes	☐ No
Radiation Seeds	☐ Yes	☐ No
Medication Patch	☐ Yes	☐ No
Diminished Renal Function	☐ Yes	☐ No

3. Females only:

Pregnant/Suspected Pregnant	☐ Yes	☐ No
Breastfeeding	☐ Yes	☐ No

Date of Last Menstrual Cycle _____/_____/_____

4. In your own words, what is your reason for this scan today?

_____

_____

5. Have you had any surgical operation or procedure?

☐ Yes ☐ No

If YES, please list surgery. _____

_____

_____

6. Have you ever been injured by a metal object? ☐ Yes ☐ No

If YES, please explain. _____

_____

_____

7. Are you allergic to I.V. contrast or iodine?

Please list allallergies and medication you are taking.

_____

_____

8. What is your approximate weight? _____

9. Date of birth? _____

10. MRI and CT patients only:

Have you ever had an MRI/CT before? ☐ Yes ☐ No

If YES, when was the last scan? _____

Are you claustrophobic? ☐ Yes ☐ No

I have read and understand the safety questionnaire and have completed it to the best of my knowledge. I understand if I have any questions, I should direct them to the MRI staff. Staff is not responsible for damage to the items taken into the testing area.

X _____ ____/____/____

Patient/Guardian Signature Date

_____

Print name

For MRI office use only

X _____

MRI safety qualified representative signature

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that is related to your past, present, or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by your physician, our office staff, and others outside our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related service. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health care operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization: as required by law; public health issues as required by law; communicable diseases; health oversight; abuse or neglect; Food and Drug Administration requirement; legal proceedings; law enforcement; coroners; funeral directors; organ donation; research; criminal activity; military activity and national security; workers compensation; inmates.

Required Uses and Disclosure: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 64 500.

Other permitted and required uses and disclosures will be made only with your consent, authorization, or opportunity to object, unless required by law.

You may revoke this authorization at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

2.Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information: Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; protected health information that is subject to law that prohibits access to protect health information.

You have the right to request a restriction of your protected health information: This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment, or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another health care provider.

You have the right to request to receive confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e., electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made of your protected health information.
We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

3.Complaints

You may complain to us or to the Secretary of Health Services and Human Services if you believe yourprivacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of yourcomplaint. **We will not retaliate against you for filing a complaint.**

This notice was published and became effective on/or before April 4,0. We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by telephone at our main phone number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

_____ _____ / _____ / _____

Print Name Date

_____

Signature

Life Sciences PARTNERS

Consent for Purposes of Treatment, Payment, and Health Care Operations

I consent to the use or disclosure of my protected health information by Life Sciences Partners for the purpose of analyzing, diagnosing, or providing treatment to me, obtaining payment for my health care bills, or to conduct health care operations of diagnostic imaging. I understand that analysis, diagnosis, or treatment of me by Life Sciences Partners may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or health care operations of the practice. Life Sciences Partners is not required to agree to the restrictions that I may request. However, if Life Sciences Partners agrees to a restriction that I request, the restriction is binding on Life Sciences Partners. I have the right to revoke this consent, in writing, at any time, except to the extent that Life Sciences Partners has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer, or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have been provided with a copy of the Notice of Privacy Practices of Life Sciences Partners. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of health care operations of LifeScience Imaging. It also describes my rights and duties of LifeScience Imaging with respect to my protected health information.

LifeScience Imaging reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of Life Sciences Partners and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____

Signature of Patient or Personal Representative

_____

Printed Name of Patient

_____ / _____ / _____ _____

Date of Signing Description of Personal Representative's Authority

Life Sciences PARTNERS

Authorization for Release of Protected Health Information

I hereby authorize the use and disclosure of my individually identifiable health information as described below.

I understand that signing this authorization is voluntary and that if I refuse to sign this form it will not prevent receipt of health care or eligibility for benefits under a health plan.

I understand that I am entitled to receive a copy of this form upon signing it.

I understand that if the organization or individual authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

I understand that I have a right to revoke this authorization, but that I must send a written revocation to the address below. I also understand that the revocation applies to uses and disclosures made after the revocation is made.

_____ _____

Patient Name **ID Number**

Person or organization authorized to release my health information:

_____ _____

Name Phone Number

_____ _____ _____

City State Zip

_____

Specific description of information that is to be disclosed (include dates):

_____

Purpose of the disclosure:

_____

This authorization will expire on (date or event):

_____ _____/_____/_____

Patient Signature Date

_____

Patient Name (print)

If signed by a patient representative:

_____ _____

Representative Name (print) Relationship to Patient and Authority Status

This form does not authorize the use of psychotherapy notes.

Assignment of Proceeds, Contractual, Lien, and Authorization ("Agreement")

I hereby direct any and all insurance carriers, attorneys, governmental agencies, companies, individuals, and/or other legal entities ("payers"), which may elect, or be obligated, to pay proceeds to me for any reason, to pay directly to, and exclusively to the name of Life Sciences Partners (LSP) in the amount of the full charges incurred by me at the office, past or future, including but not limited to, charges for treatment, narrative reports, depositions, testimony, and other charges incurred by me at the office ("my charges"). I further grant a contractual lien to I hereby direct any and all insurance carriers, attorneys, governmental agencies, companies, individuals, and/or other legal entities ("payers"), which may elect, or be obligated, to pay proceeds to me for any reason, to pay directly to, and exclusively to the name of LSP in the amount of the full charges incurred by me at the office, past or future, including but not limited to, charges for treatment, narrative reports, depositions, testimony, and other charges incurred by me at the office ("my charges"). I further grant a contractual lien to LSP with respect to my changes; however, I understand that nothing in this agreement shall be constructed as an election by LSP to claim protection under any statutory lien law. For the purpose of this agreement, proceeds shall include, but not be limited to, proceeds from any settlement, judgment, or verdict, as well as proceeds relating to the following insurance coverages: individual/group health, disability, worker's compensation, medical payments benefits, personal injury protection, lost wages, lost services, no-fault benefits, uninsured and underinsured motorist coverage, liability coverage, and malpractice coverage.

I further agree that, in the event a payer refuses to pay LSP, I hereby assign to the Office, in so far as permitted by law, the following: all of my rights, remedies, and benefits to LSP, as well as any and all causes of action that I might have against such payer to the extent of my charges, the right to prosecute such causes of action either in my name or in the Office's name, and the right to settle or otherwise resolve such causes of action as the Office sees fit.

In the event that I retain one or more attorneys to represent me in this matter, I direct each attorney to issue a letter of protection to LSP regarding my charges. Upon issuance, I agree that letter(s) of protection cannot be revoked or modified without the expressed written consent of the Office. I further direct and the Office hereby requests each attorney to provide immediate notice to the Office regarding any funds received by the attorney relating to my accident, to promptly pay the office out of such funds, and to provide a full accounting of such funds to the Office upon its request.

I hereby authorize and direct LSP to file my claims with my health insurance. I understand, however, that in the event my charges are submitted in their full amount to any other form of insurance or sources of payment (e.g., liability, attorneys, etc.), I hereby authorize and direct LSP to collect any write-offs or discounts issued by my health insurance, out of the proceeds from the other insurance or source of payment.

I hereby direct all payers to release to LSP any pertinent information regarding any coverage I may have, including but not limited to: the amount of the coverage, the amount paid thus far, and the amount of any outstanding claims. I authorize this Office to release any information regarding my treatment or pertinent to my case(s) to all payers as defined above to facilitate collection under this Agreement. I hereby direct this Office to file a copy of this Agreement, together with any applicable charges, with any or all payers, regardless of whether a claim has been established with said payers. I hereby authorize LSP to endorse/sign my name on any and all dependents, regardless of whether these other charges are related to my condition.

I understand that I remain personally responsible for the total amounts due toLSP for their services. This agreement does not constitute any consideration for this Office to await payments and it may demand payments from me immediately upon rendering services at its option. If this Office must take action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse LSP for all costs of such collection efforts, including, but not limited to, all court costs and all attorney fees.

This agreement shall not be modified or revoked without the mutual written consent to LSP and myself. I hereby revoke any previously signed authorizations, whether executed at this office or any other office to the extent that the terms of those authorizations conflict with the terms of this agreement.

I agree that each and every provision of this Agreement is reasonably necessary for the protection of the rights and interests of LSP and myself. However, should any provision of this agreement be found to be invalid, illegal, or unenforceable, or for any reason cease to be binding on any party hereto, all other portions and provisions of Agreement shall, nevertheless, remain in full force and effect.

_____

Patient Name

_____

Signature of Patient / Guardian:

_____ / _____ / _____

Date of Signing