ADVANCED
IMAGING CENTER, INC.

PATIENT INFORMATION

Please Print Clearly **Today's Date**____________

PATIENT NAME____

LAST FIRST MIDDLE

DATE OF BIRTH_____/_____/_____ **SOCIAL SECURITY #** ______-______-______ **SEX M**___ **F**____

MAILING ADDRESS____

SECOND ADDRESS____

PHONE # (_________) __________________________

EMPLOYER____**PHONE**(_______)_________________

SPOUSE NAME____**DATE OF BIRTH**_____/_____/_____

LAST FIRST MIDDLE

REFERRING PHYSICIAN____

EMERGENCY CONTACT: NAME_________________________________**PHONE**(_______)_________________

RESPONSIBLE PARTY OF ACCOUNT **SAME (CHECK IF APPLICABLE)**

NAME____

DATE OF BIRTH______/______/______ **SOCIAL SECURITY #**_________-__________-__________

ADDRESS____

PHONE NUMBER(_______)______________________________

Patient Cervical Spine Screening
(Circle One)

Date Screened ____________

Patients Name	**Social Security No.**	**Age**	**Sex** Male ____ Female___	**Height**	**Weight**

	YES	**NO**		**YES**	**NO**
Dentures	___	___	Bone or Joint Pins, Rods, Nails, etc.	___	___
Teeth Fillings, or Amalgams	___	___	Brain or Aneurysm Clips	___	___
Metal Fragments in Eyes	___	___	Stents or Valve Replacements	___	___
Ever Welded or worked w/Metal	___	___	Neurostimulater (Tens Unit)	___	___
Hearing Aid or Ear Implant	___	___	Jewelry, Hairpins, Wigs, Body Piercing	___	___
Any surgery to the area of exam	___	___	Possibility of Being Pregnant	___	___
Any surgeries ever	___	___	IUD for birth control (women only)	___	___
Joint Replacement or Prosthesis	___	___	Last Menstrual Period (Start Date)	___	___

A. Any previous injury to your neck? Yes No
If so, when?____

B. Any previous surgery to your neck? Yes No
If so, when, where and what type of operation?__________________________________
____

C. Any previous X-ray, CT, Bone scan or MRI studies of your neck? Yes No
If so, when and where were they taken?______________________________________
____

D. Have you had a history of tumors, cancer, radiation therapy, chemotherapy? Yes No
If so, please explain. ____

E. Have you ever had a biopsy? Yes No

1. How long have you had pain? ____

(Check the appropriate box or boxes)

2. Where is the pain located? SHOULDERS ____ NECK ____ ARMS ____ HANDS____

3. Which side hurts worse? R ___ L ___ BOTH ____

4. Weakness? R ___ L ___ BOTH ____

5. Numbness in your fingers/hands? YES ___ NO ___

*Additional Information: ____

____

Patient Signature____

Authorization Information – Please Read Carefully

1. RELEASE OF INFORMATION:
   I authorize Advanced Imaging Center, Inc. and attending physician(s) to release any and all information acquired in the course of my examination and treatment in connection with Advanced Imaging Center, Inc. for the purpose of insurance, workers compensation and/or Medicare benefit payments. I also request the release of any x-rays which are part of the records of Advanced Imaging Center, Inc. I also authorize Advanced Imaging Center, Inc. to obtain any outside records pertaining to my exam.

2. ASSIGNMENT OF BENEFITS:
   I authorize payment directly to Advanced Imaging Center, Inc. and physician(s) accepting this assignment of all services and medical benefits applicable and otherwise payable to me but not to exceed the reasonable and customary charge for these services rendered by Advanced Imaging Center, Inc. and physician(s).

3. MEDICARE AND MEDICAID BENEFITS:
   Where Medicare and Medicaid benefits are applicable, I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician(s) services to the physician(s) or organization furnishing the services, or authorize such physician(s) or organization to submit a claim to Medicare for payment to me.

4. FINANCIAL RESPONSIBILITY:
   All professional services rendered are charged to the patient. Necessary forms will be complete to help expedite insurance carrier payments. However, the patient is responsible for all fees regardless of insurance coverage. It is also customary to pay for services when rendered unless other arrangements have been made in advance with our office bookkeeper. I understand that I am responsible to Advanced Imaging Center, Inc. and physician(s) for reasonable charges incurred by me and not paid by third party benefits. In the event that the Advanced Imaging Center Inc. bill, or any party thereof, is deemed delinquent, I understand that I will be responsible for collection expenses as well as reasonable attorney's fees and court costs if suit is initiated.

5. RESPONSIBILITY FOR PERSONAL VALUABLES:
   I also understand that I am responsible for all articles (money, documents, radios, jewelry, dentures, eyeglasses, etc.) and/or clothing which I retain in my possession (on my person) and for any other articles and/or clothing which may be brought by me while I am having services rendered at Advanced Imaging Center, Inc. I hereby release Advanced Imaging Center, Inc., physician(s) and/or any employees from any claim for loss of, damage to or complete destruction of such property.

6. I, the below named patient, hereby give my consent for treatment to all radiologists and technicians associated with Advanced Imaging Center, Inc.

7. HIPAA NOTICE OF PRIVACY PRACTICES:
   My signature on this document acknowledges that I have received Advanced Imaging Center Inc.'s HIPAA Notice of Privacy Practices

The undersigned certifies that he or she has read and understands the foregoing and is the patient or is duly authorized by the patient as the patient's general agent to execute this form and accept its terms (copy to patient upon request).

____ ____________________

Patient Date

____ ____________________

Patents Agent or Representative (or Parent/Legal Guardian if a Minor) Relationship to Patent

____

Witness