Patient Registration

Account #
Chart #

PATIENT INFORMATION		
Last Name:	First Name:	MI:
SSN:	Date of Birth: _______/_______/_______	
Sex: ☐ M ☐ F	Preferred Pronouns: ☐ He/Him ☐ She/Her ☐ They/Them	
Marital Status: ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Never Married		
Address:	Apt/Unit:	
City:	State:	Zip:
Mobile Phone:	Home Phone:	Work Phone:
Email:	Pharmacy:	Pharmacy Phone:
Primary Care Provider:	Primary Care Provider Phone:	
Primary Care Provider Address:		

PRIMARY INSURANCE INFORMATION	SECONDARY INSURANCE INFORMATION
Is the patient covered by insurance? ☐ Y ☐ N	Does patient have secondary insurance? ☐ Y ☐ N
Insurance Co:	Insurance Co:
ID #:	ID #:
Group #:	Group #:
Name of Insured: ☐ Same as patient	Name of Insured: ☐ Same as patient
**If not same as patient fill out below:*	**If not same as patient fill out below:*
Insured SSN:	Insured SSN:
Relation to Patient:	Relation to Patient:
Date of Birth: _______/_______/_______	Date of Birth: _______/_______/_______
Employer:	Employer:

WORK OR ACCIDENT RELATED INJURIES			
Are you here for Work-Related Injury?: ☐ Y ☐ N	If yes, BWC: ☐ Y ☐ N	Claim #:	
Active: ☐ Y ☐ N	Date of Work-related Injury:		
Are you here for an auto-accident related injury?: ☐ Y ☐ N			
Are you here for non-auto accident related injury?: ☐ Y ☐ N	Type:	Date of Accident:	
Attorney Name:	Phone number:		

EMERGENCY CONTACT	
Contact Name:	Contact Name:
Phone:	Phone:
Alternate Phone:	Alternate Phone:
Relation to Patient:	Relation to Patient:

Please bring the following to your first appointment:

- ☐ Photo identification
- ☐ Health insurance card(s)
- ☐ Medications or a list of the medications you are currently taking
- ☐ A list of known allergies
- ☐ Patient Registration forms (if you've filled them out in advance)

Patient Registration

AUTHORIZATION AND RELEASE

By signing this consent form I acknowledge that I have read, understand, voluntarily consent to and authorize the following:

Authorization of Treatment:

I authorize examination, diagnosis and general treatment (including, but not limited to, the use of x-rays, diagnostic tests and non-invasive/minimally invasive procedures to be performed by physicians and staff at Dayton Outpatient Center (DOC). I realize that if surgery is required, I will be given additional information.

Guarantee of Payment:

INSURED: Assignment of Benefits: I authorize payment directly to Dayton Outpatient Center and its entities for all benefits otherwise payable to me. I understand that I am financially responsible for all charges not covered by insurance. I authorize Dayton Outpatient Center and its entities to submit claims to my insurance carrier(s), as well as medical records required to evaluate these claims for payment.

SELF-PAY/UNINSURED: Current self-pay rates apply and are due prior to or at the time of service, before leaving our facility.

Communications:

I consent to receive healthcare alerts from DOC and its entities via text, email, and patient portal.

Receipt of Privacy Practices:

By signing this consent form, I acknowledge that a copy of the Notice of Privacy Practices has been offered to me. I understand that the notice covers all entities of Dayton Outpatient Center including DOC Pain Management, DOC Vein Management, DOC Imaging Services, DOC Physical Therapy, Miami Vally Ambulatory Surgery Center, Access Surgery Center of Ohio, Dayton Anesthesia Associates, AccessMD Urgent Care and Meta Medical Research Institute. Meta Medical Research Institute may use data for screening purposes if you chose to participate in a clinical trial. I understand that DOC reserves the right to change their notice and information practices and that I may obtain a copy of the revised notice by requesting a copy from the office manager.

Release of Medical Records:

I authorize Dayton Outpatient Center and its Affiliates to release verbally, electronically and/or in writing confidential medical information obtained during the course of my examination and/or treatment to any person or entity including my insurance carrier, employer (if treatment is related to employment), and/or other healthcare provider(s) for purposes of treatment, payment of charges, quality assurance and utilization review. I understand that should I choose not to release my medical records to a specific entity and/or person(s) I must specifically state so in writing for inclusion in my medical record.

Patient Signature: ____ Date: ________________

Responsible Party: ____ Date: ________________

No-Show and Cancellation Policy

1. If cancellation is necessary, we require that you contact our office at least 24-hours in advance for office visits and procedures to avoid a potential cancellation fee

2. A "no-show" or missed appointment without 24-hour notification may be charged a fee of $50 for Office Visits or $100 for Procedures and Diagnostic Testing (incl. Ultrasounds). These fees are not billable to your insurance company and will be patient's responsibility.

3. Repeated missed appointment may result in the termination of the physician/patient relationship

4. If you are 15 or more minutes late for your appointment, the appointment may be canceled and rescheduled

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Patient Responsibility

Below fees are not billable to your insurance company and will be patient's responsibility.

Deductibles:
Is the amount you have to pay for healthcare services before your insurance plan starts to pay. You are responsible for the full amount of office visits, diagnostic testing, and procedures until the deductible amount is met each year.

Co-Pays:
Based on your agreement with your insurance plan, a copay is required to be paid at time of service before your insurance will pay. After we file a claim to your insurance plan(s) after your visit and any procedures performed, if there is any remaining amount left after your insurance pays, we will send you a statement for the balance.

Co-Insurance:
A percentage you pay for covered health care services (for example 20% of the allowed amount). Your insurance plans will determine the amount they will allow as payment for a certain item or service, where a set percentage of that "allowed amount" will be the patient's responsibility.

Patient Account Balances:
If you accumulate a balance on your account, DOC requires that you settle your balance within 30 days before your balance transfers to a debt collection agency. If you are unable to do so, DOC policy requires you to create a clear payment plan with our Patients Account team before seeing the doctor.

Your signature below indicates that you have read this policy, understand it and agree to comply with its requirements.

Patient Name: ____________________

Patient/Legally Responsible Person Signature: ____________________ Date: ____________

Medical History

PATIENT INFORMATION	
Height:	Weight:
Tobacco Use: ☐ Y ☐ N How much? ______ PPD; ______ Yrs.	
Alcohol Use: ☐ Y ☐ N How much?	

Please list your past surgeries with dates or provide list:

Past Surgery 1:	Surgery Date:
Past Surgery 2:	Surgery Date:
Past Surgery 3:	Surgery Date:
Past Surgery 4:	Surgery Date:
Past Surgery 5:	Surgery Date:
Past Surgery 6:	Surgery Date:
Past Surgery 7:	Surgery Date:

Please list your current Medications or provide list:

Medication 1:
Medication 2:
Medication 3:
Medication 4:
Medication 5:
Medication 6:
Medication 7:

Please list your current Allergies or provide list:

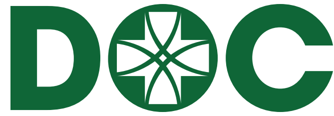
Allergy 1:
Allergy 2:
Allergy 3:
Allergy 4:
Allergy 5:
Allergy 6:
Allergy 7:

Have you ever been diagnosed with any of these? (check any that apply)

☐ Angina	☐ Coronary Heart Disease	☐ Kidney Stones
☐ Arthritis	☐ Diabetes	☐ Liver Disease
☐ Blood Disorders	☐ Heart Attack	☐ Seizures
☐ Cancer	☐ Hepatitis	☐ Stroke
☐ CHF	☐ High blood Pressure	☐ Thyroid Disease
☐ COPD/Emphysema	☐ Intestinal Issues	☐ Ulcers/Gastritis

Have you ever had any of the following happen to you? (check any that apply)

☐ Head (history of trauma)	☐ Passing Out	☐ Diarrhea/Constipation
☐ Bloody Stool	☐ Bloody Urine	☐ Shortness of Breath
☐ Skin Rash	☐ Upset Stomach/Nausea	☐ Weakness/Loss of Strength
☐ Painful Joints	☐ Swelling	☐ Dizziness
☐ Allergies	☐ Depression/Anxiety	☐ Eyesight Changes
☐ Chest Pain	☐ Hearing Loss	☐ Alcohol/Substance Abuse



Informed Consent for MRI With or Without Contrast Injection

Patient Name: ____ Date: _______________________

Date of Birth: _____ /_____ /_________ Weight: ______________________

I, the undersigned, being either the patient named above or legally authorized representative of he patient named above, do hereby consent to the performance of medical diagnostic and imaging procedures at DOC Medical Imaging, on the terms and conditions more fully set out below. I understand that I have the right to be informed about the diagnostic imaging procedure being used so that I may make the decision whether or not to undergo the procedure.

1. Consent to Imaging Procedure: Your attending physician believes it beneficial for you to undergo a diagnostic imaging procedure known as magnetic resonance imaging (MRI) to obtain additional information that may aid in diagnosing and treating your medical condition. It has been explained to me that MRI does not use x-rays or radiation. Instead a magnetic field and radio waves are used to create an image of internal body structures. MRI is a painless procedure that only requires that you lie quietly on a table that gently glides you into the magnet. While the scanner is performing your scan, you will hear some humming and thumping sounds. These are normal and should not worry you. In some cases, a contrast agent may be injected into your vein in order to give a clearer image of the area being examined. The MRI study may be conducted without the injection of contrast, but the images may not be as helpful to the radiologist and your physician. Inform the technologist if you wish to refuse the contrast injection.

2. Because of the magnetic field and radio frequencies, people with a heart pacemaker, brain aneurysm clips, and some implanted metallic or electrical devices should not have an MRI. It is important that you inform the technologist if you have any of these metallic appliances. Please inform the technologist if you are pregnant or think that you may be pregnant.

3. Potential Risks: Anytime an injection is given there is the potential for bruising or swelling at the injection site. Occasionally, minor allergic reactions occur in the form of itching, sneezing, hives, swelling of the eyes, wheezing or nausea. These symptoms may require treatment with medication we have at hand. Rarely, a more serious reaction will occur. A doctor will evaluate the situation and determine if additional medical treatment is necessary. Even though it is extremely rare, medical statistics indicated that a fatality might occur from the injection of contrast.
If you have a kidney disorder or are pregnant or breast feeding, you* ***MUST* *inform the technologist.**
DO NOT BREAST FEED FOR 24 HOURS AFTER CONTRAST INJECTION.

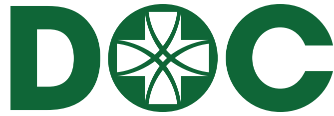
4. The benefit of this exam is to assist your physician with making a diagnosis. There may be other imaging alternatives, however your physician believes the MRI to be the best diagnostic test for you, after evaluating your symptoms and medical condition.

5. There are no post instructions for your MRI, you can eat, drink, take medications, do everything as normal.

By my signature below, I hereby certify that I have fully read this consent, had it explained to me or have had it read to me. I have been given an opportunity to ask questions about my condition, alternative forms of treatment, and the procedures to be used, and the risks and hazards involved. I understand its contents and have sufficient information to give this informed consent.

Patient/Parent/Legal Guardian Signature: ______________________________________ Date: _______________________

Technologist Signature: ____ Date: _______________________



DOC Medical Imaging Services

Please Indicate if you have any of the following					
Aneurysm Clip(s):	☐ Y	☐ N	Vascular Access Port and/or Catheter:	☐ Y	☐ N
Cardiac Pacemaker:	☐ Y	☐ N	Radiation Seeds or Implants:	☐ Y	☐ N
Implanted Cardioverter Defibrillator (ICD):	☐ Y	☐ N	Piece of metal lodged or stuck in eye:	☐ Y	☐ N
Electronic Implant or Device:	☐ Y	☐ N	Medication Patch (Nicotine, Nitroglycerin):	☐ Y	☐ N
Magnetically-Activated Implant or Device:	☐ Y	☐ N	Any Metallic Fragment or Foreign Body:	☐ Y	☐ N
Neuro-stimulation System:	☐ Y	☐ N	Are you Diabetic?:	☐ Y	☐ N
Spinal Cord Stimulator:	☐ Y	☐ N	Tissue Expander (e.g. Breast):	☐ Y	☐ N
Internal Electrodes or Wires:	☐ Y	☐ N	Surgical Staples, Clips, or Metallic Sutures:	☐ Y	☐ N
Bone Growth/Bone Fusion Stimulator:	☐ Y	☐ N	Joint Replacement (hip, knee, etc.):	☐ Y	☐ N
Cochlear, Otologic, or Other Ear Implant:	☐ Y	☐ N	Bone/Joint Pin, Screw, Nail, Wire, Plate, etc.:	☐ Y	☐ N
Insulin or Other Infusion Pump:	☐ Y	☐ N	IUD, Diaphragm, or Pessary:	☐ Y	☐ N
Implanted Drug Infusion Device:	☐ Y	☐ N	Dentures or Partial Plates:	☐ Y	☐ N
Any Type of Prosthesis (eye, penile, etc.):	☐ Y	☐ N	Tattoo or Permanent Makeup:	☐ Y	☐ N
Heart Valve Prosthesis:	☐ Y	☐ N	Body Piercing Jewelry:	☐ Y	☐ N
Eyelid Spring or Wire:	☐ Y	☐ N	Hearing Aid (Remove before entering MRI system room):	☐ Y	☐ N
Artificial or Prosthetic Limb:	☐ Y	☐ N	Other Implant: ___________________________	☐ Y	☐ N
Metallic Stint, Filter, or Coil:	☐ Y	☐ N	Claustrophobia:	☐ Y	☐ N
Shunt (spinal or intra-ventricular):	☐ Y	☐ N	Previous MRI, if yes where: ________________	☐ Y	☐ N
Previous History of Cancer:	☐ Y	☐ N	Are you on Dialysis:	☐ Y	☐ N
Any History of Kidney Problems:	☐ Y	☐ N	Are you Pregnant:	☐ Y	☐ N
History of Liver Disease:	☐ Y	☐ N			

Important Instructions: Before entering the MRI environment or MRI System room, you must remove all metallic objects including hearing aids, dentures, partial plates, keys, beeper, cell phone, eyeglasses, hair pins, barrettes,. jewelry, body piercing jewelry, watch, safety pins, paperclips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clipper, tools, clothing with metal fasteners & clothing with metallic threads.

Please consult the MRI Technologist or Radiologist If you have any questions or concerns.

Note: You may be advised or required to wear earplugs or other hearing protection during the MR procedure to prevent possible problems or hazards related to acoustic noise.

WARNING: Certain implants, devices or objects may be hazardous to you and/or may interfere with the MR procedure. DO NOT enter the MR system room or MR environment if you have any question or concern regarding an implant, device or object Consult the MRI Technologist or Radiologist BEFORE entering the MR system room. The MR system magnet is ALWAYS on.

I attest that the above information is correct to the best of my knowledge. I read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form and regarding the MR procedure that I am about to undergo.

Signature of Person Completing Form: ____ Date: ____________________

Form Completed By: ☐ Patient ☐ Relative ☐ Nurse: ______________ Relationship to Patient: ____________________

Form Information Reviewed By: ____ GFR Result: ______________________

☐ MRI Technologist ☐ Nurse ☐ Radiologist