

SIKER IMAGING, LLC

PATIENT REGISTRATION

MR # _____

DATE _____

PATIENT INFORMATION (PLEASE PRINT)

SEX M F

NAME (FIRST) _____ (MI) _____ (LAST) _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

TELEPHONE (HOME) _____ CELL _____ WORK _____

SSN _____ DATE OF BIRTH _____ EMAIL _____

EMPLOYER _____ PHONE _____

EMPLOYER ADDRESS _____

PRIMARY CARE PHYSICIAN (PCP) _____ PHONE _____

WHO REFERRED YOU? _____ PHONE _____

IN CASE OF EMERGENCY NOTIFY _____ PHONE _____

PREFERRED PHARMACY _____ PHONE _____

RESPONSIBLE PARTY FOR PAYMENT (Must be filled out if patient is less than 18 years of age.)

NAME _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

TELEPHONE (HOME) _____ CELL _____ WORK _____

MOTOR VEHICLE ACCIDENT OR WORKERS COMPENSATION CLAIM NUMBER _____

INSURANCE NAME _____ DATE OF ACCIDENT/INJURY _____

INSURANCE ADDRESS _____

ADJUSTERS NAME _____ PHONE _____

PRIMARY INSURANCE

INSURANCE NAME _____ PHONE _____

SUBSCRIBER NAME _____ RELATIONSHIP _____ DOB _____

INS ADDRESS _____ CITY _____ STATE _____ ZIP _____

ID NUMBER or SOCIAL SECURITY NO. _____ GROUP or PLAN NO. _____

SECONDARY INSURANCE

INSURANCE NAME _____ PHONE _____

SUBSCRIBER NAME _____ RELATIONSHIP _____ DOB _____

INS ADDRESS _____ CITY _____ STATE _____ ZIP _____

ID NUMBER or SOCIAL SECURITY NO. _____ GROUP or PLAN NO. _____

Siker Imaging. LLC

MRI PATIENT SCREENING FORM

NAME _____ DATE _____ MR # _____

DATE OF BIRTH _____ HEIGHT _____ WEIGHT _____

You will be undergoing an exam that uses very powerful magnetic radio frequency waves. This requires that we get a complete and accurate screening prior to having the exam. By not providing us with a complete history you are putting your health at risk for injury or death.

YES NO Have you had any prior imaging studies on the area to be scanned today?
Did you bring them with you today or do you have them? _____
Where taken _____ When _____ Type _____

YES NO Do you have a history of Asthma?

YES NO Do you have any allergies to medications or other drugs? List _____

YES NO Do you have a history of allergic reaction to contrast media or iodine?
Describe reaction _____
Was medication prescribed for the reaction? _____

YES NO Do you have a history of allergies to shellfish or seafood?

YES NO Do you have any blood, kidney or respiratory problems? Explain _____

YES NO Do you have diabetes? Are you taking glucophage? _____

YES NO Are you pregnant? If yes, how many weeks? _____

YES NO Are you nursing? If yes, do you have breast milk saved? _____

YES NO Have you had any incident of metal in the eyes?
If yes, was it removed by a doctor? _____ Do you repeatedly get metal in the eyes? _____

YES NO Have you had any brain surgery or special procedure?
If yes, when? _____ Where? _____
Name of Physician/Surgeon _____

YES NO Have you had any ear surgery or special procedure?
If yes, when? _____ Where? _____
Name of Physician/Surgeon _____

YES NO Have you had any eye Surgery or special procedure?
If yes, when? _____ Where? _____
Name of Physician/Surgeon _____

YES NO Have you had any heart surgery or special procedure?
If yes, when? _____ Where? _____
Name of Physician/Surgeon _____

YES NO Do you have a Cardiac Pacemaker?

YES NO Do you have and Internal Cardiac Defibrillator?

YES NO Do you have any type of implanted stimulator?

YES NO Do you have any type of magnetic implants?

YES NO Do you have any type of implanted pumps?

YES NO Are you undergoing a procedure involving a pill cam at this time?

YES NO Do you have any aneurysms clips? If yes, do you have an implant card? _____

YES NO Do you have any ear implants? If yes, do you have an implant card? _____

YES NO Do you have any eye implants? If yes, do you have an implant card? _____

YES NO Do you have implanted coils, filters or stents? If yes, do you have an implant card? _____

YES NO Do you have a halo vest? If yes, what type of halo vest? _____

YES NO Do you have a heart valve replacement or annuloplasty ring?
If yes, do you have an implant card? _____

YES NO Have you had an abdominal aortic aneurysm repair?
If yes, do you have an implant card? _____

YES NO Have you had a PDA, ASD, or VSD repair? If yes, do you have an implant card? _____

YES NO Do you have any bullets, pellets, metal fragments or shrapnel in the body?
If yes, please describe type and location _____

YES NO Do you have breast tissue expanders or implants? If yes, do you have an implant card?

YES NO Do you have an IUD, pessary or diaphragm? If yes, what type? _____

YES NO Do you have a penile implant? If yes, do you have an implant card? _____

YES NO Do you have any joint replacements? If yes, where? _____

YES NO Do you have any screws, plates, pins, or other orthopedic implants?
If yes, where? _____

YES NO Do you have any body piercings? If yes, where? _____

YES NO Do you have any type of skin patches? Explain _____

YES NO Do you have any tattoos or permanent makeup? Where? _____

YES NO Do you have any other metal/ electronic objects inside or on your body?
If yes, explain _____

PATIENT SIGNATURE _____ DATE _____

SIGNATURE OF PERSON COMPLETING THIS FORM _____

SIGNATURE OF EMPLOYEE CLEARING PATIENT FOR EXAM _____

Spine Imaging Questionnaire

Name: _____

Date: ___/___/___

DOB: ___/___/___

1. Location of initial pain/symptoms:

___ Neck

___ Back

___ Arm: ___ Right ___ Left

___ Upper back

___ Leg: ___ Right ___ Left

___ Middle back

___ Lower back

2. What pain/symptoms bother you the most?

___ Aching pain (please describe)

___ Shooting shock-like pain down your arm(s) or leg(s) – (please describe)

3. Are you having any other pain/symptoms?

___ Weakness

___ Numbness

___ Tingling

___ Bowel or bladder changes

___ Burning

___ Other (please describe)

___ Mass

4. Have you ever had surgery involving this area of your body?

___ No ___ Yes ___ Number of surgeries

What type of surgery: _____

Name of surgeon: _____

Date: _____

5. Was the pain/symptoms brought on by an injury/accident? If yes, when and how?

6. What activities increase pain/symptoms?

___ Sitting

___ Squatting

___ Standing

___ Lifting

___ Walking

___ Lying down

___ Bending backwards

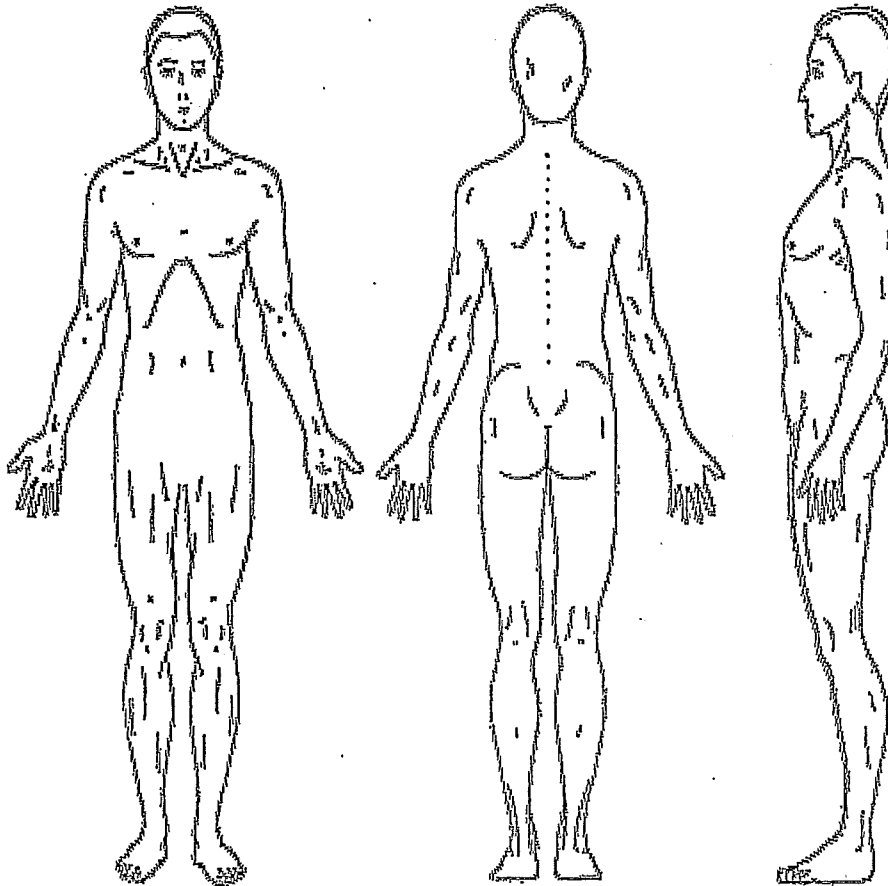
___ Other (please describe)

___ Bending forward

CONTINUED ON BACK

7. Please shade the area(s) of pain/symptoms with appropriate letter.

W—WEAKNESS N—NUMBNESS T—TINGLING B—BURNING



RIGHT LEFT LEFT RIGHT

Siker Imaging, LLC

Our Financial & Release of Information Policy

Patient Responsibility: Patients are responsible for all charges resulting from treatment provided by Siker Imaging, LLC. We bill most insurance carriers. However, primary responsibility for the account is yours. Payment is due within 30 days of the first billing, unless other financial arrangements are made. Established patients with a delinquent balance may be asked for payment at time of service.

Minors: Patients under 18 years of age will be the responsibility of the custodial parent(s).

Insurance Billings: It is your responsibility, (or that of the financially responsible party), to provide current, accurate insurance billing information. If your insurance information changes, please provide the new insurance information prior to receiving additional care. If your insurance coverage is not in effect at the time you receive care, or if your plan does not cover the services that you receive, you will be responsible the pay the charges.

Medicare: Our physicians are participating providers. We will bill Medicare as your primary insurer. We will also bill your supplement insurance.

Medicaid: Please bring your current medical card with you to each appointment. If you are restricted to a primary care physician by Oregon's Medical Assistance Program or Washington's Department of Social and Health Services, you must obtain a referral to the specialist by them.

Check Returned: It is our office policy to charge all patients a \$35.00 fee for checks that are returned.

CANCELLATION POLICY: Due to procedure related expenses, any appointment that is cancelled without more than 24-hours notice is subject to a \$100 charge.

Additionally: If a patient is more than 15 minutes late, his/her appointment is subject to cancellation or rescheduling.

Authorization to Release Information:

I have read and I accept this policy for my testing and/or treatment with Siker Imaging, LLC. In obtaining payment for services, I authorize my healthcare provider, Siker Imaging, LLC, to furnish information from my medical record to any company that may be responsible for payment of all or part of my provider charges, including my insurance companies and their representatives, and my employer or union if they are involved in processing the claim.

If I have been referred by, or am being referred to, another healthcare provider, I authorize Siker Imaging, LLC to release my medical information to this provider for continuing care.

I also assign Siker Imaging, LLC all payments to which I am entitled for medical expenses related to the services reported herewith. I understand I am financially responsible for all charges whether covered by insurance or not. I also understand that balances outstanding for more than 90 days will be subject to a processing fee.

I, OR MY APPOINTED AGENT, HAVE READ, FULLY UNDERSTAND AND AGREE TO THE ABOVE STATEMENTS. I HAVE RECEIVED A COPY OF THIS INFORMATION.

Patient Name (print)

Patient's Signature

Date

IF PATIENT IS UNDER THE AGE OF 15 YEARS, OR IS OTHERWISE UNABLE TO SIGN, COMPLETE THE FOLLOWING

Patient is _____ year(s) of age or is unable to sign because: _____

Signature

Relationship to Patient

Date

Sign Below if Disclosure of Information is not authorized:

Therefore, I agree to pay for costs of all treatment and services personally.

Signature of Guarantor

Date

Signature of Patient

Date

SIKER MEDICAL IMAGING AND INTERVENTION

PRIVACY NOTICE

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.

Our organization is committed to providing you with medical care that meets your needs. An important aspect of our service commitment to you is the protection and security of the protected health information that we obtain about you. We have always safeguarded your health information and our written privacy policy gives us an opportunity to share with you our policies that protect your health information.

We are required by law to provide you with this notice. It will describe to you what protected health information we collect about you and how that information might be used.

The Type Of Protected Health Information That We May Obtain About You:

Demographic Information: including your name, address, date of birth, phone number(s), name of your employer, your spouse or other family members, and emergency contact.

Insurance Information: including your insurance carrier, the name of the insured person, insurance identification numbers, and benefits and eligibility information.

Health Information: including your health history, past illnesses or injuries, family medical history, your social activities including use of tobacco, alcohol, or drugs, family life and living situation, your current and/or ongoing health problems, including medications, allergies, advised treatment and outcomes of that treatment.

Payment Information: including your insurance carrier, your record of charges, adjustments, and payments to our organization.

How We May Use and Disclose Protected Health Information About You:

Section 1:

We are not obligated to have your consent when using or disclosing protected health information for the following purposes:

- A. **For Treatment:** We may use and disclose your health information to provide, coordinate or manage your health care and any related services. We may disclose information about you to doctors, dentists, nurses, technicians, office staff or other personnel who are involved in taking care of you and your health.

For example:

- ◇ *If we schedule a test, therapy or surgery for you, we must provide information about you in order to complete the scheduling. This includes your name, demographic and insurance information and the reason for the test.*
- ◇ *Your doctor may share your medical information with another doctor who is also involved in your care so that both may have all the information to make the best treatment decisions for you.*
- ◇ *We may share information with a pharmacy so that they can fill or refill a prescription for you.*
- ◇ *We may share information about you with another provider who is on call in the absence of your provider.*

- B. **For Payment:** We may use and disclose your information to obtain payment for services you receive.

For example:

- ◇ *We may use or disclose your information to determine eligibility for insurance or benefits.*
- ◇ *We may use the name of your insurance carrier and your identification numbers in order to file a claim for you.*
- ◇ *We may disclose your information about your conditions or reasons for seeking care and the care that is provided to your insurance carrier so that they may process and pay your claim.*
- ◇ *We may disclose information about your conditions to your insurance carrier to seek approval as necessary for recommended tests and treatment.*
- ◇ *We may provide information about your services to a health care clearinghouse so that they may distribute a claim to your insurance carrier on our behalf.*

- ◇ *If we refer you to another facility or provider we may provide them with your insurance information to expedite your registration and assure that they are participants in your insurance plan.*

C. For Health Care Operations: We may use or disclose protected health information about you in order to evaluate our care for you or to meet a business need of the organization. These activities include quality assessment activities, employee review activities, training students, compliance audits by your insurance carrier, and conducting or arranging for other business activities.

For example:

- ◇ *We may use information about you to evaluate the performance of our staff in caring for you.*
- ◇ *We may use your information to evaluate our efficiency.*
- ◇ *We may use your information to evaluate and respond to a patient complaint.*
- ◇ *We may share your health information with students or residents who are learning to care for patients.*

We may also use or disclose protected health information to our Business Associates in the performance of health care operations. A Business Associate is an entity or person engaged by this organization to perform a business activity on behalf of the organization. Our Business Associates are obligated by contract to protect health information they receive or generate about you.

For example:

- ◇ *We may provide information to our transcription service so that they can produce a written copy of your encounter in our office.*
- ◇ *We may provide information to our accountant in order to prepare our organization's financial reports.*
- ◇ *We may share information with qualified consultants in order for them to provide business management advice.*

D. Other Contact Situations:

- ◇ We may use your information to call and remind you of an appointment in our office.
- ◇ We may tell you about or recommend possible treatment options or alternatives that may be of interest to you.
- ◇ We may tell you about health-related products or services that may be of interest to you.

E. Special Situations:

Emergencies: We may use or disclose protected health information in the case of a medical emergency.

Required by Law: We may use or disclose your protected health information if the disclosure is required by law.

Public Health: We may disclose protected health information about you for public health activities. These activities generally include the following:

- ◇ To prevent or control disease, injury or disability
- ◇ To report births or deaths
- ◇ To report child abuse or neglect
- ◇ To report reactions to medications or problems with products
- ◇ To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition
- ◇ To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight: We may disclose protected health information to health oversight agencies that oversee our activities. These activities may include audits, investigations and inspections and are necessary for the government to monitor the health care system, government programs and compliance with civil rights laws.

Lawsuits or Disputes: If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. Subject to legal requirements, we may also disclose medical information about you in response to a subpoena.

Law Enforcement: We may disclose protected health information, so long as all applicable legal requirements are met, for law enforcement purposes.

Coroners, Medical Directors and Funeral Directors: We may disclose protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release information about patients to funeral directors as necessary to carry out their duties.

Workers Compensation: We may disclose medical information about you for programs that provide benefits for work-related injuries or illness.

Military Activities, National Security and Intelligence Activities: If you are a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to disclose protected health information about you. We may also disclose information about foreign military personnel to the appropriate foreign military authority.

Organ and Tissue Donation: If you are an organ or tissue donor, we may disclose protected health information to organizations that handle organ or tissue procurement when necessary to facilitate organ or tissue donation or transplantation.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. The release would be necessary 1) for the institution to provide you with health care; 2) to protect your health and safety or the health and safety of others; or 3) for the safety and security of the correctional institution.

Serious Threats: As permitted by applicable law and standards of ethical conduct, we may use or disclose protected health information if we, in good faith, believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

Information that is not personally identifiable: We may use or disclose information about you in a way that does not personally identify you.

Section 2:

Protected Health Information Use and Disclosure That Requires an Opportunity for You to Agree or Object

Family and Friends: We may disclose your protected health information to your family or friends or any other individual identified by you when they are involved in your care or the payment of your care. We will only disclose the protected health information directly relevant to their involvement in your care or payment. If you are available, we will give you an opportunity to object to these disclosures, and we will not make these disclosures if you object.

If you are not available, we will determine whether a disclosure to your family or friends is in your best interest, and we will disclose only the protected health information that is directly relevant to their involvement in your care.

Section 3:

Protected Health Information That Cannot Be Disclosed Without Your Specific Authorization:

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below.

You may revoke this authorization by notifying us in writing at any time.

Your Rights as a Patient:

◇ **You have the right to inspect and copy your protected health information.**

You may inspect and obtain a copy of your protected health information maintained in our office. We may charge you for the cost of copying, mailing or associated supplies.

Under federal law, however, you may not inspect or copy psychotherapy notes or information compiled in reasonable anticipation of a civil, criminal or administrative action or proceeding. Certain documents pertaining to laboratory services are also exempt under federal law.

Under certain circumstances, we may not grant your request. If we deny your request, then you may appeal our decision.

We require that requests to access your protected health information be made in writing. You can arrange to do this through our Privacy Officer.

◇ **You have the right to request a restriction of your protected health information.**

You may ask us not to disclose your protected health information for treatment, payment or health care operations. You may also request that any part of your protected health information not be disclosed to friends and/or family members involved in your care.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency care.

In order to request a restriction, you must do so in writing. The request must specifically state what information is restricted and to whom the restriction applies.

You may request a restriction form from our Privacy Officer.

◇ **You have the right to request to receive confidential communications from us by alternative means or at an alternative location.**

You may request that we communicate with you in a certain way or at a specific location. We will attempt to accommodate all reasonable requests.

Please contact our Privacy Officer to make this request in writing. Your request must specify where or how the communication is to be directed.

- ◇ **You have the right to request that we amend your protected health information.**
If you believe that protected health information we have about you is incorrect or incomplete, you may request an amendment to this information.

We may not grant your request if we determine that the protected health information that is the subject of your request:

- ◇ was not created by our organization
- ◇ is not a part of your medical or billing records
- ◇ is information that you are not permitted to inspect or copy
- ◇ is already a complete and accurate record

Amendment requests must be made in writing and must include a reason for requesting the amendment. If you wish to amend your record, you may contact our Privacy Officer for a form.

- ◇ **You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.**

You have the right to receive an accounting of disclosures of protected health information made by us to individuals or entities other than you, except for disclosures:

- ◇ to carry out treatment, payment and health care operations as described above
- ◇ to persons involved in your care or for other notification purposes as provided by law
- ◇ for national security or intelligence purposes as provided by law
- ◇ to correctional institutions or law enforcement officials as provided by law
- ◇ that occurred prior to April 14, 2003

You are allowed one free disclosure per each twelve-month period. If you wish additional disclosures within that twelve-month period, we may charge you the cost of providing the disclosure list.

Your request for a disclosure accounting must be made in writing. Please contact our Privacy Officer to obtain a form.

- ◇ **You have the right to file a complaint.**

If you believe that your privacy rights have been violated, you have a right to file a complaint in the form of a written letter with our office and with the Secretary of Health and Human Services without fear of retaliation.

A letter of complaint filed with this office should be sent to our Privacy Officer at the address listed below.

- ◇ **You have the right to request and receive a paper copy of this notice from our office.**

Revisions to Our Privacy Notice:

We are required to abide by the terms of this Privacy Notice. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with a revised Privacy Notice. You may obtain this by calling our office and requesting that a revised copy be sent to you in the mail, or by asking for one at the time of your next appointment.

Questions/Contact:

If you have questions about this document, or have questions about privacy or patient rights, please contact our Privacy Officer.

Privacy Officer Name: Genevieve

Address: 1800 NE Second Ave Portland, Or 97212

Phone Number: 503-595-3967

PRIVACY NOTICE ACKNOWLEDGEMENT

To Our Patients:

Federal law requires that we provide you with a copy of our Privacy Notice.

The Privacy Notice explains how we may use and disclose health information about you. We ask that you sign this form for our records so that we may document your receipt of the Notice.

If you have questions about the Privacy Notice, please feel free to direct these to our Privacy Officer at any time. The name and contact number of the Privacy Officer is listed on your copy of the Privacy Notice.

Patient Name: _____ Date of Birth: _____

Patient to complete this section

I have received a copy of the Privacy Notice for this organization on today's date.

Signed: _____ Date: _____

If patient is unable to acknowledge receipt, staff member providing notice to complete this section

The Privacy Notice was provided to

Patient Name: _____ On _____

The patient was unable to acknowledge receipt of the Privacy Notice for the following reason:

Signed: _____

File this form in the patient's chart