SOCAL RADIOLOGY

COVID-19 SCREENING

PLEASE READ EACH QUESTION CAREFULLY	PLEASE CIRCLE THE ANSWER THAT APPLIES TO YOU	
Have you experienced any of the following symptoms in the past 48 hours: • fever or chills • cough • shortness of breath or difficulty breathing • fatigue • muscle or body aches • headache • new loss of taste or smell • sore throat • congestion or runny nose • nausea or vomiting • diarrhea	**YES**	**NO**
Within the past 14 days, have you been in close physical contact (6 feet or closer for at least 15 minutes) with a person who is known to have laboratory-confirmed COVID-19 or with anyone who has any symptoms consistent with COVID-19?	**YES**	**NO**
Are you isolating or quarantining because you may have been exposed to a person with COVID-19 or are worried that you may be sick with COVID-19?	**YES**	**NO**
Are you currently waiting on the results of a COVID-19 test?	**YES**	**NO**

Patient Signature:	Date:

cdc.gov/screening

REV20200727

www.SoCalRadiology.net

PATIENT REGISTRATION FORM

6276 River Crest Dr.
Suite D.
Riverside, CA. 92507
888-480-9996 PH
909-614-7473 Fax

Today's Date: _____ Referring Physician: _____

Patient Information:

Last Name: _____ First Name: _____ Middle Initial: ___

Sex: ____ Date of Birth: _____ Marital Status: _____

Address: _____ Apt #: _____ City: _____ State: ___ Zip Code: _____

Home Phone #: _____-_____-_____ Work Phone #: _____-_____-_____ Cell #: _____-_____-_____

Is Patient a Minor? Yes ❑ No ❑ If yes, parent/guardian name:

Emergency Contact:

Name: _____ Relationship to patient: _____

Street Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone #: _____-_____-_____ Cell #: _____-_____-_____ Work Phone #: _____-_____-_____

Insurance Information:

Primary Insurance:

Insurance Name: _____

Policy #: _____

Group #: _____

Insured Name: _____

DOB: _____ Insured SSN: _____

Relationship to the patient: _____

Secondary Insurance:

Insurance Name: _____

Policy #: _____

Group #: _____

Insured Name: _____

DOB: _____ Insured SSN: _____

Relationship to the patient: _____

Consent and Acknowledgement

I authorize SoCal Radiology to release any medical or other information needed for this or a related claim. If assignment is accepted, I request payment of insurance benefits be made directly to SoCal Radiology. I am responsible for the deductible, co-payment, and non- covered service (as determined by my insurer.) I understand that any deductible or coinsurance payments made on this exam date are estimates based on information SoCal Radiology received from my insurance company prior to submission of the claim for this exam. Once a claim is submitted to my insurance carrier for the exam, I understand that I may be responsible for additional amounts in accordance with my individual insurance plan and acknowledge that SoCal Radiology will bill me for the balance remaining. I authorize release of information, films, and copies pertinent to my medical history and for follow-up of any suspicious finding. This consent authorizes SoCal Radiology to release to my insurance company, referring physician and other physicians participating in my care my medical record, including images and reports.

I acknowledge that I reviewed the Notice of Privacy Practices, as required by HIPAA. I understand I may request a paper copy of this policy to keep.

Signature of Patient/Parent/Guardian: _____ Date: _____

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate**: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review or arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided on a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated:** It is the intention of the parties that this agreement bind all parties whose claims may arise out of or related to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must communicate in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, nit supplant, any other applicable statutory or common law.

Either party shall have the absolute right it arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity, which would otherwise be a proper additional party in a court action and upon such intervention and joinder, any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Section 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrations a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05; however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in once proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days, or signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: **Retroactive Effect:** If patient intends this agreement to cover services rendered before the date it is Effective as of the date of first medical services.

_____
Patient's or Patient Representative's Initials

If any provision if this arbitration agreement is held invalid of unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT, YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: _____ Patient's or
Patient Representative's Signature (Date)

By: _____ _____
Physicians or Authorized Representative's Signature (Date) By: _____
Print Patient's Name

SoCal Radiology

Print or Stamp Name of Physician, Medical Group or Association Name

(If Representative, Print Name and Relationship to Patient)

A signed copy of this document is to be given to Patient. Original is to be files in Patient's medical records.

MRI Patient History and Screening

Patient Name: _____ Referring Doctor: _____Date: _____

Height: _____ Weight: _____ Date of Birth_____ Age: _____

Main Symptom (Reason for visit): _____

MRI is a very strong magnet. Before you are permitted to enter we must know if you have any metal in your body. Metal objects can interfere with your scan and can be dangerous; please answer the following questions carefully.

Do you have any of the following? (Please circle Yes or No)

Pacemaker	Yes	No	Hearing Aid/Wig	Yes	No
Internal Defibrillator	Yes	No	Artificial Prosthesis (Eye, Limb)	Yes	No
Brain Aneurysm Clip	Yes	No	Cochlear or Stapes Ear Implant	Yes	No
Programmable Shunt	Yes	No	Eye Lid Springs or Wires	Yes	No
Non-Programmable Shunt	Yes	No	Retinal Tacks or Buckle	Yes	No
Intravascular Stents/Coils/Filters	Yes	No	Permanent Tattooed Makeup (Eyeliner)	Yes	No
Metal Worker (Welder)	Yes	No	Dentures, Retainers, Braces, Partials	Yes	No
Injury to eye involving metal	Yes	No	Electronic Ankle Device	Yes	No
Neurostimulator	Yes	No	Breast Tissue Expander	Yes	No
Implanted Insulin Pump	Yes	No	IUD	Yes	No
Implanted Drug Infusion Pump	Yes	No	Medication Skin Patch	Yes	No
Carotid Artery Vascular Clamp	Yes	No	Penile Implant	Yes	No
Heart Valve Prosthesis	Yes	No	Claustrophobic	Yes	No

Any Other Implants such as (Please circle): Orthopedic Pins/Rods/Screws/Nails/Wires/Bullets/Shrapnel, etc. If yes, where?_____

Do **you** have a history of Tumor, Cancer or Lymphoma? _____If yes, what type? _____

Do **you** have a history of Kidney Disease or Renal Failure? _____

Please list your **Allergies**: _____

Are you now or could you be **pregnant?** _____ Are you Breast Feeding? _____

I attest that the above information is correct to the best of my knowledge.

Patient/Guardian Signature: _____Date_____

PLEASE REMOVE ALL ITEMS OUT OF YOUR POCKETS PRIOR TO YOUR EXAM

Medical Release Form

6276 River Crest Dr. Suite D
Riverside, CA 92507

General Information: (888) 480-9996
Medical Records: (909) 614-7473, mail@SoCalRadiology.net

Date _____ _____

I, _____ _____

Patient's Name | Date of Birth

CD

☐ Request a CD of my _____ / _____

Exam | Date

Signature X _____

REPORTS

☐ Request reports of my _____ / _____

Exam | Date

☐ Hand Carried or ☐ Mailed to:

Name: _____

Address: _____

_____

I authorize ***SoCal Radiology*** to mail a report to the above listed name and address.

Signature X _____

HIPAA NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES

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. *SoCal Radiology* is required by law to maintain the privacy of your health information and is strongly committed to maintaining your privacy. Additionally, *SoCal Radiology* is required to provide you with a notice of its legal duties and privacy practices. *SoCal Radiology* will not use or disclose your health information except as described in this Notice. This Notice applies to all of the health information generated by *SoCal Radiology* , as well as information we receive from others, including health care providers and health plans.

USES AND DISCLOSURES OF YOUR HEALTH INFORMATION TREATMENT: *SoCal Radiology* may use and disclose your health information to provide and coordinate your healthcare treatment. We may disclose all or part of your health information to your attending physician, consulting physicians, nurses, technicians, or other health care providers who have a legitimate need for such information in your care and treatment. *SoCal Radiology* may also use or disclose your health information to tell you about or recommend treatment alternatives that may interest or benefit you, or to remind you about an appointment.

PAYMENT: *SoCal Radiology* may use and disclose health information about you for payment purposes, including determining coverage, billing, claims management, medical data processing, and reimbursement. The information may be released to an insurance company, third party or other entity (or their authorized representatives) involved in the payment of your medical bill, and may include copies or excerpts of your medical record that are necessary for payment of your account. For example, a bill sent to a third party payer may include information that identifies you, your diagnosis, and the procedures and supplies used.

ROUTINE HEALTHCARE OPERATIONS: *SoCal Radiology* may use and disclose your health information for routine healthcare operations, including but not limited to quality assurance, medical review, internal auditing, licensing or credentialing activities of *SoCal Radiology* , and educational purposes. *SoCal Radiology* may engage outside companies ("business associates") to carry out certain aspects of these healthcare operations. *SoCal Radiology* may need to disclose your health information to the business associates to enable them to perform their duties. Examples of business associates include, but are not limited to, medical transcriptionists, third-party billing companies, accountants, and lawyers. *SoCal Radiology* requires the business associate to also sign an agreement to protect the confidentiality of your health information.

USES AND DISCLOSURES REQUIRING YOUR AUTHORIZATION *SoCal Radiology* will obtain a written authorization from you before it uses or discloses your protected health information, unless a particular use or disclosure is expressly permitted or required by law without your authorization. You have the right to revoke any authorization you have previously given by submitting a written statement of revocation to *SoCal Radiology* .

USES AND DISCLOSURES TO WHICH YOU MAY OBJECT *SoCal Radiology* may disclose your health information to a friend or family member who is involved in your medical care and for disaster relief purposes. If you have any objection to the use and disclosure of your health information in this manner, please tell us.

USES AND DISCLOSURES THAT ARE REQUIRED OR PERMITTED WITHOUT AUTHORIZATION REGULATORY AGENCIES: *SoCal Radiology* may disclose your health information to government and certain private health oversight agencies, e.g., the Department of Public Health and Environment, the Joint Commission on Accreditation of Healthcare Organizations or the Board of Medical Examiners, for activities authorized by law, including, but not limited to, licensure, certification, audits, investigations and inspections. These activities are necessary to monitor compliance with the requirements of government programs.

LAW ENFORCEMENT/LITIGATION: *SoCal Radiology* may disclose your health information for law enforcement purposes, judicial proceedings, and other disputes as required by law or in response to a court order.

PUBLIC HEALTH: As required by law, *SoCal Radiology* may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.

WORKERS' COMPENSATION: *SoCal Radiology* may disclose health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.

MILITARY/VETERANS: *SoCal Radiology* may disclose your health information as required by military command authorities, if you are a member of the armed forces.

HIPAA NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES

CORONERS: Upon your death, *SoCal Radiology* may disclose your health information to a coroner or medical examiner for purposes of identifying you or determining a cause of death, and to funeral directors as necessary to carry out their duties.

NATIONAL SECURITY: *SoCal Radiology* may disclose health information about you to authorized officials for intelligence, counterintelligence, and any other national security activities authorized by law.

RESEARCH: *SoCal Radiology* may use and disclose your health information for reviews preparatory to research and, if approved by a privacy board or institutional review board, research studies.

AS OTHERWISE REQUIRED BY LAW: *SoCal Radiology* will disclose your health information in any situation in which such disclosure is required by law (e.g., child abuse, domestic abuse, or to prevent harm to you or other individuals).

YOUR RIGHTS RELATED TO YOUR HEALTH INFORMATION Although all records concerning your treatment obtained at the UMIH are the property of the *SoCal Radiology* , you have the following rights concerning your health information:

RIGHT TO CONFIDENTIAL COMMUNICATIONS: You have the right to receive confidential communications of your health information by alternative means or at alternative locations. For example, you may request that the only contact you at work or by mail.

RIGHT TO INSPECT AND COPY: You generally have the right to inspect and copy your health information, except as restricted by law.

RIGHT TO AMEND: You have the right to request an amendment or correction to your health information. If we agree that an amendment or correction is appropriate, we will ensure that the amendment or correction is attached to your medical record.

RIGHT TO AN ACCOUNTING: You have the right to obtain a statement of the disclosures that have been made of your health information, except for the purposes of treatment, payment or routine operations (as detailed above), or if you have provided an authorization.

RIGHT TO REQUEST RESTRICTIONS: You have the right to request restrictions on certain uses and disclosures of your health information. *SoCal Radiology* generally is not required to abide by your requested restrictions. However, if you pay in full out of pocket for a health care item or service, we must comply with your request to restrict the disclosure of health information related to that health care item or service to a health plan for payment or health care operations purposes.

RIGHT TO RECEIVE COPY OF THIS NOTICE: You have the right to receive a paper copy of this Notice, upon request.

RIGHT TO REVOKE AUTHORIZATION: You have the right to revoke your authorization to use or disclose your health information, except to the extent that action has already been taken in reliance on your consent or authorization.

RIGHT TO RECEIVE CERTAIN NOTICES: You have a right to receive notice of certain breaches of the security of certain protected health information.

FOR MORE INFORMATION REGARDING HOW TO EXERCISE THESE RIGHTS If you have questions or would like more information regarding any of the rights listed above, please contact *SoCal Radiology* at the address or telephone number listed below.

IF YOU BELIEVE THAT YOUR RIGHTS HAVE BEEN VIOLATED You may file a complaint with *SoCal Radiology* or with the Secretary of the Department of Health and Human Services. To file a complaint with

6276 River Crest Dr. Suite D. Riverside, CA 92507. All complaints must be submitted in writing. There will be no retaliation for filing a complaint.

EFFECTIVE DATE: The effective date of the Notice is January 1 20*21*.

Name:_____

Signature:_____ **Date:**_____