Cayman Medical Ltd.
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Patient Registration Form

Patient Information

First Name:		**Last Name:**		**Middle Name:**	
DOB:		**Sex:**			
Primary Phone:		**Other Phone:**			
Primary e-mail:		**Other e-mail:**			
Marital Status:					
Address:					
Address:					
City:		**State:**		**Country:**	**Postal:**
Notes:					

Emergency Contact Information

First Name:		**Last Name:**		**Middle Name:**	
DOB:		**Sex:**			
Primary Phone:		**Other Phone:**			
Primary e-mail:		**Other e-mail:**			
Marital Status:					
Address:					
Address:					
City:		**State:**		**Country:**	**Postal:**
Notes:					

Insurance Information (use policy holder information)

First Name:		**Last Name:**		**Middle Name:**	
DOB:		**Sex:**			
Primary Phone:		**Other Phone:**			
Primary e-mail:		**Other e-mail:**			
Marital Status:					
Address:					
Address:					
City:		**State:**		**Country:**	**Postal:**
Insurance Company Name:		**Plan Name:**			
Effective Date:		**Expiration Date:**			
Relationship (i.e. self)					
Member ID:		**Group ID:**			
Notes:					

Notice of Privacy Practices, Financial Responsibility, Consent for Treatment

PATIENT INFORMATION

Last Name	First Name	Middle Initial	Suffix	DOB DD/MM/YYYY
				___/___/_____

Please complete the following information regarding how we may contact you regarding treatment, test results, or status of your account.

Can we contact you at your home phone?	☐ Yes	☐ No
Can we leave a voice mail on your home phone?	☐ Yes	☐ No
Can we contact you on your mobile phone?	☐ Yes	☐ No
Can we leave a voice mail on your mobile phone?	☐ Yes	☐ No
Can we send you medical information about your visit through our secure online patient portal?	☐ Yes	☐ No

PERMISSIONS

☐ Yes, I give permission to verbally discuss my medical condition(s), treatment, and information regarding my treatment with the following individual(s):

_____/_____
Name/Relationship

_____/_____
Name/Relationship

_____/_____
Name/Relationship

☐ No, I do not give permission to discuss my medical condition(s), treatment, and information regarding my treatment with anyone else.

ACKNOWLEDGEMENT

My signature on this form acknowledges that I have been made aware (and can request a copy) of Cayman Medical's **Privacy Notice.** I also acknowledge that I am aware that I may address questions regarding the contents of the document at the Center prior to my visit.

My signature on this form also acknowledges that I have read the Cayman Medical's **CONSENT FOR SERVICE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION**, **PATIENT FINANCIAL RESPONSIBILITY AGREEMENT**, and **GENERAL CONSENT FOR CARE AND TREATMENT** below and agree to the outlined terms.

CONSENT FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby consent that Cayman Medical's Team may use or disclose Protected Health Information (PHI) through verbal, written, analog or digital (ePHI) ways to carry out payment, diagnostics or treatment. I authorize release of any information concerning me (or my child's) health care, advice and treatment provided for thepurpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits and agree to pay any remaining balance once my Insurance Plan has processed my claim.

PATIENT FINANCIAL RESPONSIBILITY AGREEMENT

The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees.

As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill. You are responsible for payment of any deductible and co-payment/ co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. You are responsible for informing your provider if a specific medical, imaging or laboratory facility is required by your insurance carrier for any medical, imaging or laboratory services ordered. Many insurance companies have additional stipulations that may affect your coverage.

You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full.
I have read the above policy regarding my financial responsibility to Cayman Medical, for providing services to me or the above-named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Cayman Medical, the full and entire amount of bill incurred by me or the above-named patient; or, if applicable any amount due after payment has been made by my insurance carrier. If I do not have health insurance and will be responsible for services rendered here at Cayman Medical, I agree to pay Cayman Medical the full and entire amount of treatment given to me or to the above-named patient. I understand that for any balances over 90 days old, Cayman Medical reserves the right to refer the account to a collection agency where an additional collection fee may be added to the total balance due.

Self-Pay Policy

- If you are a self-pay patient, you will be required to pay the deposit for the office visit before services are rendered
- In addition, any remaining balance on your account will be collected at time of discharge

Workers Compensation Policy

- It will be your responsibility to contact us with the name and address of your employer or the insurance company that covers your employer

GENERAL CONSENT FOR CARE AND TREATMENT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This Consent Form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This Consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended: and (2) you consent to treatment in this Center or any other satellite office or Center under common ownership. This Consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your provider about the purpose, potential risks, and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, you are encouraged to ask questions.

I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has been brought me to seek care at this Center. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s). I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____ ____/____/_____

Patient or Guardian Signature Date DD/MM/YYYY

MRI SCREENING AND CONSENT

Patient Name:_____DOB_____

Type of MRI Scan: _____

Current Medical Complaint: _____

Previous Surgeries: _____

Prior Imaging Studies: _____

Answering the following questions will assist us in determining if it is safe for you to have an MRI.

Do you have a pacemaker, wires, defibrillator, or implanted heart valves?	Yes	No	
Have you had a recent (4 weeks) CABG (heart bypass) surgery?	Yes	No	
Have you ever had any head surgery requiring aneurysm clips?	Yes	No	
Have you ever been exposed to metal fragments that could be in your eyes/body?	Yes	No	
Do you have a hearing aid, middle/inner ear prosthesis, or dentures?	Yes	No	
Do you have any metal in your body? Do you have a prosthesis?	Yes	No	
Do you have any type of electronic device (i.e. stimulator or pump) in your body?	Yes	No	
Do you have any tattoos, body piercing(s), or magnetic eye lashes?	Yes	No	
Do you wear a transdermal patch?	Yes	No	
Do you have a history of panic attacks or a fear of enclosed or narrow places?	Yes	No	
Have you been prescribed a sedative by your referring physician for this procedure?	Yes	No	
**If yes, you understand that you should not drive after taking the sedative?	Yes	No	NA
If you are a woman – are you pregnant or is it possible that you might be pregnant?	Yes	No	NA
If you are a woman – are you breastfeeding?	Yes	No	NA

List any food and/or drug allergies:_____

CONTRAST – GADOLINIUM

You were provided the Dotarem Medication Guide to read, ask any questions you might have, and sign. Dotarem has been used safely in millions of patients but reactions such as headaches, nausea, and vomiting occasionally occur. Extremely rare serious reactions include respiratory distress or even death. If you are nursing, you may want to refrain from breastfeeding and discard all breast milk for 48 hours after the injection of gadolinium.

History of IV contrast media?	Yes	No	Allergic to contrast:	Yes	No
History of Hypertension:	Yes	No	History of diabetes:	Yes	No

History of kidney or hepatic disease, organ transplant, or pending organ transplant: Yes No

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I attest that the above information is correct to the best of my knowledge. I have read and understand the entire contents of this form. I feel that I have adequate knowledge and sufficient time upon which to base my consent to the procedure and/or the use of gadolinium.

Signature of patient/guardian: _____ Date:_____

Technologist: _____ Date: _____

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Contrast Type		Correct Patient	
Contrast Dose		Correct Patient Position	
Lot		Correct Site	
Expiry			
Tech Signature		Radiologist	