COMPASS HEALTH

SETTING A NEW DIRECTION IN HEALTH CARE

Patient Registration Form

Today's Date:_____

Social Security #:_____

First Name_____Middle _____

Last Name_____

Sex: M F Date of Birth: _____

Marital Status _____

Referring Physician _____

Home Address _____

_____

City_____State_____Zip _____

Home Phone (_____)_____

Work/Cell Phone (_____)_____

Circle One: Employed Retired Full-Time Student

Employer_____

Insurance Information

Primary Insurance Coverage

Insurance Name: _____ Policyholder's Name: _____

Relationship to policyholder:____Self___Spouse___Child___Parent____Other: _____

Policyholder's Employer: _____ Policyholder's Date of Birth: _____

Secondary Insurance Coverage

Insurance Name: _____ Policyholder's Name: _____

Relationship to policyholder:____Self___Spouse___Child___Parent____Other: _____

Policyholder's Employer: _____ Policyholder's Date of Birth: _____

Emergency Contact

Name: _____ Relationship: _____

Home Phone: (_____)_____ Work/Cell Phone: (_____)_____

Guarantor/Responsible Party (*if applicable*)

Full Name_____Relationship: _____

Social Security #_____Date of Birth:_____ Sex: M F

Home Phone (_____)_____ Work/Cell Phone (_____)_____

Home Address:_____

I certify that all of the above information is true and accurate, and will notify Compass Health of any changes as necessary.

Patient/Guardian Signature: _____ Today's Date: _____

COMPASS HEALTH

SETTING A NEW DIRECTION IN HEALTH CARE

Compass Health

Informed Consent for CT Scan With *or* Without Contrast Injection

IMPORTANT: IF YOU ARE PREGNANT OR THINK THAT YOU *MAY* BE PREGNANT,

PLEASE INFORM THE FACILITY PERSONNEL AT ONCE

Your physician has requested that we perform a computerized tomography scan (CT) to obtain additional information. This is a diagnostic test that uses x-radiation (x-ray) and a computer to produce images of internal body parts.

As part of your examination, we may need to inject you with a contrast solution containing iodine. This clear, odorless liquid is removed from your body by your kidneys and will not alter the appearance of your urine. It will show up on the images to provide important diagnostic information. Soon after the injection, you may experience a metallic taste and a warm sensation. You may feel some nausea. These feelings last only a short time.

Occasionally, minor allergic reactions occur in the form of itching, sneezing, hives, swelling of the eyes, or wheezing. These symptoms may require treatment with medication we have on hand. It is very important that you inform the technologist if you experience any of the condition mentioned in this form. Rarely, a more serious reaction will occur. Even though it is extremely rare, medical statistics indicate that a fatality may occur from the injection of contrast.

If you have had a reaction to a contrast injection previously or a history of asthma or other allergic conditions, any history of diabetes or kidney disorder, anemia or sickle cell anemia, **if you are taking Glucophage, are pregnant or breast feeding you MUST inform the technologist**.

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

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, the procedures to be used, and the risks and hazards involved. I understand its contents and have sufficient information to give this informed consent.

_____ Date_____ Time_____

Patient/Parent/Legal Guardian Signature

_____ Date_____ Time_____

Witness Signature

COMPASS HEALTH

SETTING A NEW DIRECTION IN HEALTH CARE

Financial Responsibility Agreement

I understand and agree that I will be financially responsible for any and all charges for services not paid by my insurance for my visit(s) to Compass Healthcare, PLC and any non- affiliated company involved in my care. This includes medical services and visits, preventative exams and physicals, lab testing, x-ray, EKG, and any other screening service or diagnostic testing ordered by the physician's staff.

I understand and agree it is my responsibility and not the responsibility of the physician or clinic to know if my insurance will pay for my medical service or visit, preventative exam or physical, lab testing, x-ray, EKG, or any other screening service or diagnostic testing ordered by the physician or the physician's staff.

I understand and agree it is my responsibility to know if my insurance has any deductible, co-payment, co-insurance, out-of-network amount, usual and customary limit, or any other type of benefit limitation for the services I receive, and I agree to make payment in full.

I understand and agree it is my responsibility to know if the physician or provider I am seeing is a contracted/in-network provider recognized by my insurance company or plan. If the physician or provider I am seeing is not recognized by my insurance company or plan, it may result in claims being denied or a higher out of pocket expense to me. I agree to be financially responsible and make payment in full.

I understand and agree it is my responsibility to know if my Primary Care Physician (PCP) choice has been processed by my insurance company or plan. If I have requested a PCP change that has not processed by my insurance company, it may result in claims being denied, and I agree to be financially responsible and make payment in full.

_____

Patient/Guarantor Signature *Today's Date*

_____

Patient/Guarantor Printed Name

COMPASS HEALTH

SETTING A NEW DIRECTION IN HEALTH CARE

Patient Disclosures & Consents

Assignment of Insurance Benefits

I hereby authorize direct payment of my insurance benefits to Compass Healthcare, PLC or the physician individually for the services rendered to my authorized dependents or me. I understand and agree that I will be responsible for any co-pay or balance due that Compass Healthcare, PLC is unable to collect from my insurance carrier. Initial: _____

Medicare/Medicaid/Champus Benefits

I certify that the information I have given by applying for payment under these programs is correct. I authorize the release of any of my records that these programs may request. I hereby direct that payment of y authorized benefits be made directly to Compass Healthcare, PLC. Initial: _____

Authorization to Release Non-Public Information

I hereby authorize Compass Healthcare, PLC or the physician to release medical or incidental, non-public, personal information that may be necessary for medical evaluation, treatment, consultation, or processing of insurance benefits. Initial: _____

Lab/X-Ray/Diagnostic Services

I understand that I may receive *a separate bill* from an entity (other than Compass Healthcare, PLC) if my medical care includes labs, x-rays, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balance due for these services if they are not reimbursed by my insurance. Initial: _____

I hereby consent to evaluation, testing, and treatment as directed by my physician, and affirm that I have read and agree with all disclosures on this form.

_____

Patient/Guarantor Signature Today's Date

_____

Patient Printed Name

COMPASS HEALTH

SETTING A NEW DIRECTION IN HEALTH CARE

Authorization for Use or Disclosure of Protected Health Information

By signing this form, I authorize Compass Healthcare, PLC to use and disclose my Protected Health Information (PHI) in the following manner:

Share my Protected Health Information with:
(Please CIRCLE and INITIAL applicable authorization)

_____My Spouse. Spouse's Name: _____

_____My parent/siblings/child(ren)/guardian. Please provide applicable names: _____

_____

_____The following person(s) _____

_____

_____DO NOT DISCLOSE MY PHI WITH ANYONE

Disclose my protected health information for the following reasons:
(Please CIRCLE and INITIAL applicable authorization)

_____To leave an appointment reminder on my answering machine/service

_____at home _____at work

_____To leave a message to return a phone call on my answering machine

_____at home _____at work

_____To leave a message to return a phone call with my family or co-worker

_____at home _____at work

_____DO NOT DISCLOSE MY PHI FOR ANY REASON STATED ABOVE

_____

Patient/Guarantor Signature *Today's Date*