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:____

DOES THE PATIENT CURRENTLY RESIDE IN A REHAB FACILITY? Y N IF YES, ADDRESS:

____

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

Ptient/Guardian Signature: ____ Today's Date: __________________

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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, or 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

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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*