CONSENT TO SURGICAL OR DIAGNOSTIC PROCEDURES.

A. (1) I acknowledge and understand that an injection of contrast material into the joint has been described to me and is to be performed during the following exam:

MRI Exam of the _____ Arthrogram _____ and that as a result of the performance of the procedure there is a material risk that the patient may suffer infection, allergic reaction, severe loss of blood, loss of function of any limb or organ, paralysis or partial paralysis, paraplegia or quadriplegia, disfiguring scar, brain damage, cardiac arrest or death.

(2) I acknowledge and understand that during the course of the procedure described in subparagraph (A.1) above, conditions may develop which necessitate the extension of the original procedure or the performance of procedure which are unforeseen or not known to be needed at the time this consent is obtained. This consent shall also extend to the treatment of all conditions which may arise during the course of such procedures including those conditions which may be unknown or unforeseen at the time consent is obtained.

B. I acknowledge, understand, and duly evidence in writing by executing this form that I have been given informed in general terms of the following:

1. A diagnosis of the condition requiring this procedure(s).	History of
2. The nature or purpose of the procedures(s)	Rule out disease
3. Material risk of the procedure(s)	"See paragraph A"
4. The likelihood of success of the procedure(s)	Good Fair Poor
5. The practical alternative to such procedure(s)	MRI exam without IV contrast
6. Prognosis if the procedure(s) is rejected	No comment

That the information described in paragraph (A) above was provided through the use of videotapes, pamphlets or other means of communication. Conversation with the responsible physician, or the radiology technologist under the supervision and control of the responsible physician or other medical personnel involved in the course of treatment, nurses, physician's assistant, trained counselor, or patient educator.

C. I acknowledge and understand that there are practical alternatives to the procedure(s) described in paragraph (B) alternatives, which reasonable prudent physicians generally recognize and accept.

D. I acknowledge and understand that this request for consent to perform diagnostic service shall be valid for the responsible physician for all medical personnel under the direct supervision and control of the responsible physician and for all other medical personnel otherwise involved in the procedure(s) or the course of treatment. I have been given ample opportunity to ask questions and any questions that I have asked have been answered or explained in a satisfactory manner. By signing below, I acknowledge that I have read or had this form read or explained to me. I understand this form and I voluntarily consent to allow Dr._____ or any other physicians designated or selected by such physician and all medical personnel under the direct supervision and control of such physician and all other personnel who may otherwise be involved in performing such procedure(s) to perform the procedure(s) described or otherwise referred to herein.

NORTHSIDE RADIOLOGY Associates

Name_____ Email_____ Date _____

DOB_____ Age _____ Height _____ Weight _____ ○ Male ○ Female

Pregnant ○ Yes ○ No ○ Unknown Date of LMP: _____

Primary care physician _____**Who referred you?** _____

COMPLAINT/PROBLEM TODAY: _____

_____

Severity of pain *(0= no pain, 10=worst pain)* At best _____ At worst _____ Today _____

Is pain localized or does it affect other body areas? ○ Localized ○ Other body areas

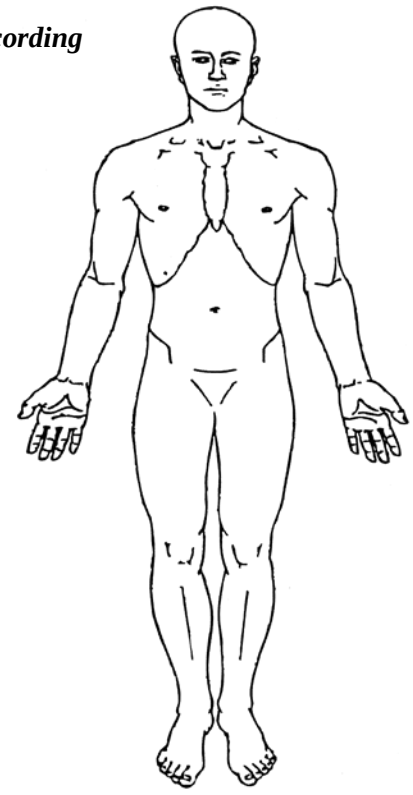
How does it affect other body areas? _____

_____

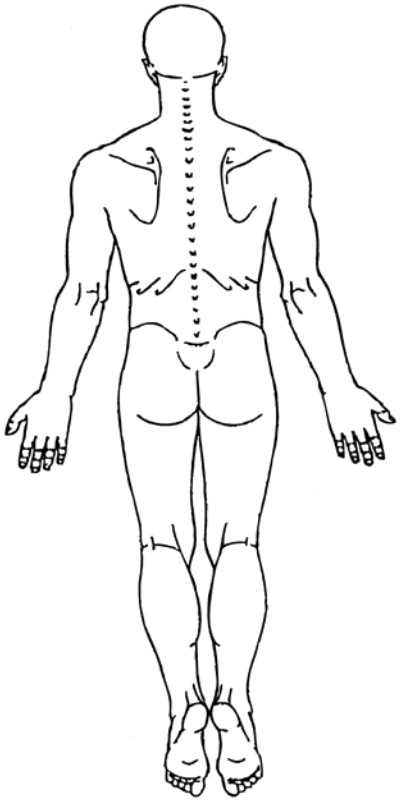
Other symptoms *(numbness, tingling, weakness, etc.)* _____

Mark these drawings according to where you hurt.

Right



Left



Form 105-13/rev 1013

Patient Name_____ Patient DOB_____

For this recent injury/illness, have you had any recent X-rays, MRI, CT, or Bone Scan? *(Please circle)*

Where: _____

LIST ALL KNOWN ALLERGIES TO MEDICATIONS: ☐ NO MEDICATION ALLERGIES

1. _____ Reaction type:_____
2. _____ Reaction type:_____
3. _____ Reaction type: _____

Are you allergic to latex? ○ Yes ○ No If so what is the allergy?_____
Any history of radiology contrast allergy or reaction? ○ Yes ○ No If so what is the allergy?_____

CURRENT MEDICATIONS: ☐ NOT CURRENTLY TAKING MEDICATION

Include herbal and over-the-counter drugs. List all medications with dosage. Using additional sheet if needed.

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Are you on blood thinners? ○ Yes ○ No ○ Unknown

Do you have a history of any bleeding problems? ○ Yes ○ No ○ if Yes, explain _____

By signing this document, I certify that the information provided by me is accurate and complete. A copy of this document may be utilized the same as the original.

_____ Date: _____
Patient/Parent/Guardian/Authorized Representative

If not signed by the patient, please indicate relationship to the patient on the line below:

_____

Reviewed By: _____ Date: _____
Physician Signature

NORTHSIDE RADIOLOGY Associates

Consent to Treat

I _____ (patient name) give permission for **Northside Radiology Associates, PC** to provide me medical treatment. While this procedure is routinely performed without incident, there may be material risks associated with these procedures. If I have any questions or concerning this procedure, I will ask my physician to provide me with any additional information. I also understand my physician may ask me to sign additional Informed Consent documents relating to a specific procedure. I understand that I have the right to refuse any procedure or treatment.

I understand that the healthcare professionals involved in my care will rely on my documented medical history, as well as other information provided by me, my immediate family, or others having information about me, in determining whether to perform the procedure. I agree to provide accurate and thorough information regarding my medical history and any conditions or events which may impact medical decision-making.

Northside Radiology Associates, PC physicians cannot guarantee any specific result(s) of any examination, treatment, procedure or medical care. I release Northside Radiology Associates, PC , its physicians and healthcare professionals from any liability for any accident or injury that is not directly caused by the negligence of Northside Radiology Associates or its employees.

_____ _____

Patient's Signature Date

_____ _____

Parent or Guardian Signature Date
(for children under 18)

_____ _____

Print name

Northside Radiology Associates, P.C.
5775 Glenridge Drive NE, Suite B525
Atlanta, Georgia 30328

NORTHSIDE RADIOLOGY Associates

Acknowledgement of Receipt of

Notice of Privacy Practices

I have received a copy of the Notice of Privacy Practices (version effective 09/23/2013) of Northside Radiology Associates, P.C.

PATIENT INFORMATION

Date

Name (Last, first, middle initial)

Street address, City, ST, ZIP Code

Signature

Date

Representative's Relationship to Patient

Please describe the Representative's authority to act on behalf of the Patient:

For Administrative Use Only:

If acknowledgement of receipt of the Notice of Privacy Practices is not obtained from the patient or the patient's representative, please explain your efforts to obtain their acknowledgement and the reason it could not be obtained:

Northside Radiology Associates P.C.
5775 GLENRIDGE DRIVE NE, BUILDING B, SUITE 525 ATLANTA, GEORGIA 30328 PHONE: 678-553-7789

NORTHSIDE RADIOLOGY Associates

Date:			PCP/Referring Physician:		
PATIENT INFORMATION					
Patient's Last Name:	First:	Middle:	Marital Status:		
Is this your legal name? (Check one) ● Yes ● No	If not, what is your legal name?	Former/Maiden Name:	Birth Date:	Age:	Sex: (Circle one) M F
Patient's Mailing Address:	City:	State:	Zip:		
	Email:				
Social Security:	Home Phone:		Cell Pho		
Occupation:	Employer:		Employe		
INSURANCE INFORMATION					
Policy Holder's Name:	Birth Date:	Address (if different):	Home Phone:		
Policy Holder's Social Security:	Employer:	Employer Address:	Employer Phone:		
Primary Insurance:		**Secondary Insurance:**			
Policy no.:	Group no.:	Patient's relationship to subscriber:			
Policy no.:	Group no.:	Patient's relationship to subscriber:			

AS A COURTESY TO OUR PATIENTS, OUR BILLING STAFF WILL FILE YOUR INSURANCE AND HELP YOU RECEIVE THE MAXIMUM BENEFITS AVAILABLE UNDER YOUR POLICY. IN MOST CASES, INSURANCE DOES NOT COVER THE FULL COST OF RADIOLOGY PROCEDURES. IT IS DESIGNED TO REDUCE YOUR COST BUT NOT ELIMINATE IT COMPLETELY. THE PATIENT OR RESPONSIBLE PARTY IS RESPONSIBLE FOR ALL FEES CHARGED BY NORTHSIDE RADIOLOGY ASSOCIATES P.C., REGARDLESS OF YOUR INSURANCE COVERAGE.

I authorize the release of medical information: 1) to process insurance claims, 2) to or from referring physicians, relevant to my care, 3) for the insurance payment to be paid directly to Northside Radiology Associates P.C., 4) by courier to physicians or other facilities relevant to my care. I understand that I am financially responsible for services rendered as patient or responsible party for the patient named above. I have read this release, and I understand and accept the terms shown by my signature below.

Patient/Guardian Signature: _____ Date: _____

Print Name: _____ Relationship to Patient: _____

Payment is expected at the time of service. Check, Cash, Visa, Mastercard, American Express, and Discover are accepted.