Capitol Imaging Centers
Locations

Please select the appropriate location below.

- **Ascension Open MRI**
  2622 S Ruby Ave Gonzales,
  LA 70737
  Office: (225) 450-6125
  Fax: (225) 450-6327

- **Baton Rouge Imaging**
  8044 Summa Ave
  Baton Rouge, LA 70809
  Office: (225) 761-7278
  Fax: (225) 767-8121

- **Bluebonnet Imaging**
  4570 Bluebonnet Blvd
  Baton Rouge, LA 70809
  Office: (225) 298-3223
  Fax: (225) 298-5474

- **Central Imaging Center**
  11424 Sullivan Rd
  Baton Rouge, LA 70818
  Office: (225) 261-7401
  Fax: (225) 261-3561

- **North Shore MRI**
  19300 North 4th St., Suite-B
  Covington, LA 70433
  Office: (985) 871-6655
  Fax: (985) 871-5050

- **Northwest Imaging**
  1460 E Bert Kouns Industrial Loop # 708
  Shreveport, LA 71105
  Office: (318) 425-1001
  Fax: (318) 425-5001

- **Open Sided MRI**
  One Galleria Boulevard
  Suite 715
  Metairie, LA 70001
  Office: (504) 837-6736
  Fax: (504) 837- 0835

Capitol Imaging Centers

PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle: _____

Address: _____

City: _____ State: _____ Zip Code: _____ Gender: ☐ Male ☐ Female

Race: _____ SSN: _____–_____–_____ DOB: _____

Employer: _____ Marital Status: ☐Single ☐Married ☐Divorced ☐Widow

Home Ph: (____) _____ Cell Ph: (____) _____ Work Ph: (____) _____

RESPONSIBLE PARTY

Name: _____ SSN: _____–_____–_____ DOB: _____

Relationship: _____ Phone: (____) _____ Email: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

INSURANCE INFORMATION

Primary Ins: _____ Policy #: _____ Group #: _____

Policy Holder Name: _____ DOB: _____

Secondary Ins: _____ Policy #: _____ Group #: _____

Policy Holder Name: _____ DOB: _____

ACCIDENT INFORMATION

Date of Accident: _____ State: _____ ☐ Work ☐ Auto ☐ Other

Adjuster Name: _____ Phone: (____) _____

PLEASE READ AND INITIAL THE FOLLOWING:

_____ CONSENT FOR MEDICAL TREATMENT: I hereby authorize Capitol Imaging Centers (CIC) to furnish the necessary medical procedure that has been ordered by my physician. I am aware that this practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of diagnostic procedures at CIC. I recognize that the physicians who practice at the Center are not employees of CIC, but are independent physicians. CIC may delegate to these independent physicians those services physicians normally provide. Any question related to my care should be directed to my physician.

_____ ASSIGNMENT OF BENEFITS: I hereby authorize CIC of any and all medical benefits applicable and otherwise payable to me. I understand that I am financially responsible to the Center for charges not covered by this assignment. I also understand that the Center is filing my claims as a courtesy to me and that unless stipulated in a contract with my carrier, I am responsible for payment of this claim.

_____ AUTHORIZATION FOR RELEASE OF INFORMATION: I hereby authorize CIC to release any information requested by this insurance company necessary to collect benefits on this claim. Unless noted below, this authorization includes, but is not limited to, the release of information related to drug, alcohol, HIV antibody and/or psychiatric testing. I further authorize any physician or institution that attended this patient previously to furnish medical records or other information that may be requested by CIC.

_____ LIFETIME MEDICARE B SIGNATURE AUTHORIZATION: I authorize any holder of medical or other information about me to the release of the Social Security Administration or its intermediaries or carriers, or to the billing agent of the Center, any information needed for this claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical benefits to be made to the holder of this assignment on my behalf. I understand that I am responsible for my health deductibles and co-insurance.

_____ WORKER'S COMPENSATION: I authorize Capitol Imaging Centers to furnish written reports of my procedure to any representative, attorney for, or investigator from my Worker's Compensation carrier concerning injuries sustained as a result of accident occurring on _____/_____/_____.

_____ IF PATIENT IS UNDER 19: I hereby give permission for _____ to be treated at CIC.

_____ HIPPA NOTICE OF PRIVACY: I have been given a copy of the notices of privacy practices of CIC.

Financial Agreement

I fully understand that I am ultimately responsible for any and all charges associated with my account at Capitol Imaging Centers. If I fail to pay any amount due and the account is referred to a collection agency and/or attorney, I will be responsible for all collection fees, court costs, attorney fees, and any other charges incurred in the collection of any balance due.

Patient Printed Name | Patient / Guardian Signature | Date

Capitol Imaging Centers

CLINICAL INFORMATION

FOR OFFICE USE ONLY

CONTRAST SUPERVISING RADIOLOGIST _____

***** *DICTATE THE RADIOLOGIST COVERING CONTRAST IN YOUR DICTATION* *****

Date: _____ Patient ID: _____ Send Films ☐ YES ☐ NO ☐ CD

Patient Name: _____

DOB: _____ Gender: ☐ Male ☐ Female

Referring Physician: _____ Phone # _____

Exam(s) Performed: _____

Physician Diagnosis: _____

Contrast Given: _____

TO BE COMPLETED BY THE PATIENT (PLEASE PRINT)

Patient Name: _____

Weight: _____

Symptoms: (Specifically describe if the pain is not in one area)

_____

_____

_____

How long have you had these symptoms? _____

Are you having any of the following? (please circle) Pain Weakness Numbness

☐ Yes ☐ No ☐ Arms ☐ Legs ☐ Right ☐ Left ☐ Both

Have you had an injury? ☐ Yes ☐ No If yes, date? _____

Have you had any type of cancer? ☐ Yes ☐ No If yes, what type? _____

List any surgeries _____

_____

Have you had a US, CT, or MRI ☐ Yes ☐ No

If yes, give date and location? _____

Do you work as a welder, sheet metal worker, or grinder? ☐ Yes ☐ No

If yes, have you had an x-ray of your eyes since working with metal? ☐ Yes ☐ No

Technologist Signature _____

Capitol Imaging Centers

NOTICE OF 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.

Capitol Imaging Centers (CIC) is committed to protecting your personal health information (PHI). As a patient of CIC, your personal health information will be used solely for the purpose of your medical treatment, payment and health care operations and how you may access this information if you choose.

When you have a diagnostic service provided by CIC, a medical record is created with your personal health information and will be used for treatment, payment and health operations. Typically your medical record contains your symptoms, examination, diagnosis, treatment and if needed, a further treatment plan for your future health care. This personal health information serves as a basis for planning your care and treatment, communicating with other health professionals who may contribute to your care and a means by which your or a third-party payer obtains the information for payment of services.

We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use of disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Your medical record is the physical property of the healthcare practitioner of facility that compiled it; however, the information belongs to you. AS provided under the Code of Federal Regulations (CFR 45) you have the right to restrict certain uses and disclosures, inspect and copy your medical record, amend your health record to the extent of incorrect information and obtain an accounting of disclosures of your medical record. You may also request to revoke your consent to use or disclose health information except to the extent those services have been previously provided prior to current consent. Request for amending your medical and/or billing records should be in writing and should include the reason for the request. Request to restrict your protected health information should be in writing and state the specific restriction requested.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Upon your request, we will provide your with any revisions of our Notice of Privacy Practices. We will not use or disclose your personal health information except as described in this notice. We reserve the right to charge a reasonable, cost-based fee for making copies.

If you have any questions and/or would like additional information, you may contact our Privacy Officer at (225) 450-6125. You may address any concerns or issues about your privacy rights with us or to the Secretary of Health and Human Services. You may file a complaint with us by notifying our Privacy Officer in writing. We will not retaliate against you for filing a complaint.

Capitol Imaging Centers

MRI QUESTIONNAIRE
PATIENT DISCLOSURE AND INFORMED CONSENT

Patient Name: _____ ID#: _____

Your doctor has requested that you have a Magnetic Resonance Imaging (MRI) examination to aid in your medical diagnosis. It is anticipated that you will benefit from this procedure, as the diagnostic imaging device may offer diagnostic information not available from other techniques.

PLEASE READ AND ANSWER YES OR NO TO THE FOLLOWING QUESTIONS:

1.	Do you have a pacemaker?	☐ Yes	☐ No
2.	Have you ever had brain surgery?	☐ Yes	☐ No
3.	Have you ever had spine surgery?	☐ Yes	☐ No
4.	Do you have aneurysm clips, stents, Coils, or filters in your blood vessels?	☐ Yes	☐ No
5.	Have you ever had ear surgery or implants?	☐ Yes	☐ No
6.	Have you ever had eye surgery or implants?	☐ Yes	☐ No
7.	Are you wearing a hearing aid?	☐ Yes	☐ No
8.	Are you wearing a wig or hairpiece?	☐ Yes	☐ No
9.	Are you wearing metallic dental appliances?	☐ Yes	☐ No
10.	Do you have a war injury or gunshot wound?	☐ Yes	☐ No
11.	Do you have any implanted devices such as electrodes, Neurostimulators, heart valves, orthopaedic implants, Shunts, infusion pump, or prosthetic appliances?	☐ Yes	☐ No
12.	Is there any possibility you are pregnant?	☐ Yes	☐ No
13.	Are you nursing an infant?	☐ Yes	☐ No
14.	Are you wearing an IUD?	☐ Yes	☐ No
15.	Do you have a concealed body piercing?	☐ Yes	☐ No
16.	Have you had radiation therapy?	☐ Yes	☐ No
17.	Have you had a contrast injection with any adverse effect?	☐ Yes	☐ No
18.	Do you have seizures?	☐ Yes	☐ No
19.	Do you have both kidneys?	☐ Yes	☐ No
20.	Are you on dialysis or in renal failure?	☐ Yes	☐ No

CONTRAINDICATIONS

Since MRI uses an electromagnetic field, you cannot undergo this procedure if you have any of the following: Cardiac pacemaker, cochlear implant, neurostimulator, metal fragment in the eye, implanted drug infusion pump (Medtronics OK) or an aneurysm clip implanted in the brain. *** Please inform us if you have any type of implant.***

PREGNANCY

The FDA has not established any criteria under which a pregnant woman may be scanned. Therefore, it is the policy of this facility that MRI imaging not be routinely performed on women with a known or suspected pregnancy.

CONTRAST

Your doctor may have requested that your exam be performed with intravenous contrast media (Optimark) if necessary during the MRI exam. Optimark is FDA approved and indicated for use with MRI examinations. Although Optimark is very safe and allergic reactions are extremely rare, the possibility of an allergic reaction does exist. In addition, related complications of the contrast procedure will be explained to your satisfaction before any injection takes place.

I confirm that the information I provided is complete and accurate to the best of my knowledge.

I have read, understand, and hereby consent to this MRI examination.

Patient Signature or Guardian if patient is a minor _____ Date _____

Witness Signature _____ Date _____

***** *PLEASE REMOVE ALL REMOVABLE METAL PRIOR TO YOUR MRI EXAMINATION* *****

Capitol Imaging Centers

RELEASE TO OBTAIN MEDICAL RECORDS

To: _____

I hereby authorize the above mentioned or any member of their professional staff to disclose, reveal, or open for observation or inspection of any report, statement, analysis, or any professional record or medical history.

I hereby waive and release any member of their staff from any restriction or privilege imposed by law in disclosing or revealing any professional record, observation or communication.

Patients Name: _____

Date of Birth: _____

_____ _____

Signature Date

_____

Social Security Number