a **Rezolut** partner

PATIENT REGISTRATION FORM

CONTACT: (909) 622-3166

LAST NAME	FIRST	MI

STREET	APT#	CITY	STATE	ZIP CODE

DATE OF BIRTH (MM/DD/YY)	AGE	SEX	SOCIAL SECURITY#	EMAIL

CELL PHONE	ALTERNATE PHONE	PATIENT STATUS
		☐ NEW ☐ RETURNING

METHOD OF PAYMENT ☐ **PPO** ☐ **HMO-IPA** ☐ **MEDICARE** ☐ **MEDI-CAL** ☐ **EWC** ☐ **SELF-PAY** ☐ **BILL DOCTOR / CLINIC**

INSURANCE CARRIER / MEDICAL GROUP	MEMBER ID#	GROUP#

IF PATIENT IS UNDER 18, ACCOMPANYING PARENT NAME

REFERRING PROVIDER / CLINIC

CONSENT TO TREATMENT AND AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I consent to and authorize the administration of all diagnostic and therapeutic treatments by Alinea Medical Imaging radiologists that may be considered advisable or necessary in the judgement of the attending radiologist. I authorize Alinea to furnish my insurance carrier(s) information regarding my history, physical findings and treatment rendered.

X DATE

AUTHORIZATION TO PAY BENEFITS AND ACCEPTANCE OF PAYMENT RESPONSIBILITY

I authorize payment of benefits directly to the provider for the services rendered. In addition, in the event that my insurance carrier(s) refuse payment for services rendered, I agree that I will be held financially responsible for payment.

X DATE

PRIOR FILM AND REPORT RELEASE

I hereby authorize the release of my films and reports in addition to any Surgical Pathology reports pertaining to my past medical history to: Alinea Medical Imaging facilities.

I hereby authorize Alinea Medical Imaging to release my films and reports to any requesting physician or medical facility providing my medical care for continuing treatment in my health care. This authorization will remain in effect for 1 year from the date of my signature.

X DATE

OFFICIAL USE

MRN: ______ DOS: __/__/__ Acc#: ______ Tech: ______ TA: ______

Staff Comments: *(does not appear on report)*

2475 N Garey Ave. Pomona, CA 91767
2700 N. Main Street, #1107 Santa Ana, CA 92705

P (909) 622-3166 | **F** (909) 622-8046
P (714) 380-6740 | **F** (909) 622-8046

www.alineamed.com

alinea MEDICAL IMAGING | a Rezolut partner

BREAST IMAGING PATIENT FORM

CONTACT: (877) 426-3926

Last: ____________ First: ____________ MI: ____________

Age: ____________ Date of Birth: ____________ Today's Date: ____________

OFFICIAL USE
MRN:

When was your last mammogram? **MONTH/YEAR** ____________ **Where?** ____________

Are you currently pregnant or breastfeeding? ☐ **NO** ☐ **YES** **Date of your last menstrual period:** ____________

1. BREAST HEALTH: Are you currently having any problems with your breasts? ☐ NO ☐ YES

If yes, please fill out the following:

Lump	☐ Right	☐ Left	☐ Both	How Long? ________
Pain or Tenderness	☐ Right	☐ Left	☐ Both	How Long? ________
Infection or Inflammation	☐ Right	☐ Left	☐ Both	How Long? ________
Recent Breast Injury	☐ Right	☐ Left	☐ Both	How Long? ________
Nipple Abnormality	☐ Right	☐ Left	☐ Both	How Long? ________
Nipple Discharge	☐ Right	☐ Left	☐ Both	How Long? ________

Please describe:

2. BREAST CANCER HISTORY: Have you ever been diagnosed with breast cancer? ☐ NO ☐ YES

If yes, please fill out the following:

Which Breast? ☐ None ☐ Right ☐ Left ☐ Both Were you diagnosed in the last two years? ________ What age? ________

Which treatments did you receive? ☐ Lumpectomy ☐ Mastectomy ☐ Breast Reconstruction ☐ Radiation Therapy ☐ Chemotherapy ☐ Prescribed Tamoxifen or Evista

Do you have a mutation in either the BRCA1 or BRCA2 gene? ☐ Never Tested ☐ Tested Normal ☐ BRCA1+ ☐ BRCA2+

3. PERSONAL CANCER HISTORY: Have you ever been diagnosed with other cancers? ☐ NO ☐ YES

If yes, please fill out the following:

Cancer Type/Location: ________________________________ *What age?* ________

4. IMPLANTS: Do you have implants? ☐ NO ☐ YES

If yes, please fill out the following:

Implant Type? ☐ Unknown ☐ Saline ☐ Silicone

5. PROCEDURES: Have you had any breast procedures... Biopsy, Reduction, MRI, etc.? ☐ NO ☐ YES

If yes, please fill out the following:

Breast Reduction/lift	☐ Right	☐ Left	☐ Both
Breast Biopsy	☐ Right	☐ Left	☐ Both

Other: ________________________________

Please describe procedure including biopsy results:

6. FAMILY HISTORY: Have family members been diagnosed with breast or ovarian cancer? ☐ NO ☐ YES

If yes, please mark the relationship as well as the age of diagnosis:

☐ Mother	☐ Sister	☐ Maternal Grandmother	☐ Paternal Grandmother	☐ Maternal Aunt	☐ Paternal Aunt
Age:_____	Age:_____	Age:_____	Age:_____	Age:_____	Age:_____

7. ACCEPTANCE:

I have been instructed regarding the importance of annual screening mammography after the age of 40.

Patient Signature: ________________________________ Date: ____________________

alinea MEDICAL IMAGING | a Rezolut partner

INFORMED CONSENT AGREEMENT: WAIVER, ASSUMPTION OF RISK, & RELEASE

Name of Patient: ____

I acknowledge that Alinea Medical Imaging, PC informed me that they are compliant with the Centers for Disease Control & Prevention guidelines to help prevent the spread of COVID-19. These include use of Personal Protective Equipment, Increased Facility Disinfection, Patient and Employee Screening and Social Distancing where possible.

By signing this agreement, I acknowledge the contagious nature of COVID-19 and voluntarily assume the risk and accept sole responsibility that I may be exposed to or infected by COVID-19 by visiting the Center and that such exposure or infection may result in personal injury, illness, permanent disability, and/or death. Being aware of these risks and the fact that there are other unknown potential risks and/or complication, it is still my desire to visit the Center.

Check below which applies to you:

☐ By signing below, I affirm that **I have not been diagnosed with COVID-19. I have not been** cleared as noncontagious by a physician, state or local public health authorities. I further affirm that **I do not believe that I have been exposed** to a person with a confirmed or suspected case of COVID-19. **I am not experiencing any new primary symptoms of illness related to COVID-19 such as a fever, cough, shortness of breath; or a combination of any additional symptoms including chills, muscle pain, headache, sore throat and/or loss of taste or smell.** I am following recommended guidelines to the greatest extent possible, e.g., practicing social distancing by participating in group activities of fewer than ten, trying to maintain separation of six feet from others, and otherwise limiting my exposure to the coronavirus.

☐ By signing below, I affirm that **I have been diagnosed with COVID-19. I have been cleared as noncontagious** by a physician, state or local public health authorities. **I have been symptom free** without fever reducing medication for at least 72 hours prior to my scheduled appointment. **I have provided to the Center verbal or written confirmation** from my referring physician that I am outside of my quarantine period. **I do not believe that I have been further exposed** to a person with a confirmed or suspected case of COVID-19. **I am not experiencing any new primary symptoms of illness related to COVID-19 such as a fever, cough, shortness of breath; or a combination of any additional symptoms including chills, muscle pain, headache, sore throat and/or loss of taste or smell.** I am following recommended guidelines to the greatest extent possible, e.g., practicing social distancing by participating in group activities of fewer than ten, trying to maintain separation of six feet from others, and otherwise limiting my exposure to the coronavirus.

☐ By signing below, I affirm that if I have been exposed to a person with a confirmed or suspected case of COVID-19, I have worn appropriate Personal Protective Equipment.

Signature: ____ Date ____________________
Patient (or Patient Responsible Party if applicable)

Staff Signature: ____________________ Print Staff Name: ____________________ Date ____________________

alinea MEDICAL IMAGING | a Rezolut partner

IMPLANT PATIENT CONSENT FOR MAMMOGRAPHY

Since you have implants we need to advise you of the following:

- The implant obscures some of the tissue so two sets of images will be taken when possible to visualize as much tissue as possible. One set of images will have the implant in the picture and another will be taken with the implant moved out of the picture.
- Implant ruptures are rare but have occurred. Like a balloon, an implant that is old or weakened can rupture at any time. This is an extremely rare occurrence but cannot be ruled out, as the condition of the implant cannot always be verified by feel prior to the mammogram.

In the first set of pictures, slight compression will be applied to your entire implant to hold it in place and prevent motion. These films are often helpful in visualizing a rupture that occurred previously. If a rupture is seen on the images the radiologist will note this in the report to your physician. Your doctor may then order an MRI as this is a more sensitive tool to look for or to view the extent of a rupture.

A second set of pictures will be taken if your implant is movable by pushing your implant back to look at the tissue in front of the implant. Normal compression must be applied and similar to a mammogram of a breast without an implant this compression may cause some slight discomfort but lasts only a few seconds. It is sometimes unavoidable to catch a tiny bit of the implant under the compression and if there is a weakness in the capsule this might cause it to leak. The same could happen if you hit that spot with any object.

Since occurrence of a rupture during mammography is rare and the benefit of mammography in early detection has been proven, we hope that you will proceed to allow us to perform your implant mammogram. Mammography is the earliest form of detection for changes in the breast but mammography is not perfect and does not detect all changes.

Puesto que usted tiene implantes tenemos que informarle de lo siguiente:

- El implante oscurece parte del tejido por lo que se tomarán dos conjuntos de imágenes siempre que sea posible para visualizar la mayor cantidad de tejido posible. Un conjunto de imágenes tendrá el implante en la imagen y otra se toma con el implante fuera de la foto.
- Roturas de implantes son raros, pero han ocurrido. Como un globo, un implante que es de edad o debilitado puede romperse en cualquier momento. Este es un acontecimiento extremadamente raro, pero no se puede descartar, como la condición de que el implante no puede siempre ser verificada por el tacto antes de la mamografía.

En el primer conjunto de imágenes, ligera compresión se aplicará a la totalidad de su implante para mantenerlo en su lugar y evitar el movimiento. Estas imagenes suelen ser útiles en la visualización de una ruptura que se produjo con anterioridad. Si la ruptura se ve en las imágenes el radiólogo tomará nota de ello en el informe a su médico. Luego, su médico puede ordenar una resonancia magnética, ya que es una herramienta más sensible para buscar o para ver el alcance de una ruptura.

Se tomará una segunda serie de imágenes si el implante se puede mover empujando su implante hacia atrás para mirar el tejido delante del implante. Compresión normal debe ser aplicada y similar a una mamografía de un seno sin un implante esta compresión puede causar una ligera molestia, pero dura sólo unos pocos segundos. A veces es inevitable para coger un poco de el implante bajo la compresión y si hay una debilidad en la cápsula que esto podría provocar que se generen fugas. Lo mismo podría suceder si usted golpea ese lugar con cualquier objeto.

La aparición de una ruptura durante la mamografía es poco común y el beneficio de la mamografía en la detección temprana se ha demostrado, esperamos que procederá a permitirnos realizar la mamografía implante. La mamografía es la forma más reciente de la detección de cambios en la mama, pero la mamografía no es perfecta y no detecta todos los cambios.

X: ______________________________ **Date** / *Fecha* ____________________

PATIENT SIGNATURE / FIRMA DEL PACIENTE

______________________________ Date: ____________________

ALINEA REPRESENTATIVE