CALIFORNIA MEDICAL MRI
A DIVISION OF NATIONS IMAGING

3760 SANTA ROSALIA DR, LOS ANGELES, CA 90008
20251 VENTURA BLVD, STE D, WOODLAND HILLS, CA 91364
2726 E FLORENCE AVE, HUNTINGTON PARK, CA 90255

(888) 811-1011 **documents@nationsmri.com**

Patient Name: _____ Sex: Male or Female

Address: _____

City, State, Zip Code: _____

Phone #: _____ SSN#: N/A

Email: _____ Date of Birth:_____

Emergency Contact: _____ Phone #: _____

Employer: _____ Phone #: _____

Work Address: _____

City, State, Zip Code: _____

Insurance: _____

ID #:_____ Group #: _____

Attorney Name: _____ Phone #: _____

Address: _____

City, State, Zip Code: _____

Date of Injury: _____

Patient Signature: _____ **Date**: _____

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Patient Name: _____ **DOB**: ____ /_____/_____

Wt.: _____ **Ht**: _____ **Sex**: ☐ M ☐ F

Implants, Devices & Foreign Bodies, Tattoos & Piercings,

☐ Yes ☐ No Aneurysm clip(s)

☐ Yes ☐ No Cardiac pacemaker / ICD

☐ Yes ☐ No Electronic/Magnetically-activated device

☐ Yes ☐ No Neurostimulator

☐ Yes ☐ No Cochlear implant or hearing device

☐ Yes ☐ No Infusion pump

☐ Yes ☐ No Prosthesis

☐ Yes ☐ No Heart valve/stent/filter/coil

☐ Yes ☐ No Shunt

☐ Yes ☐ No Tattoos/permanent makeup?

If yes, where and when:
_____

☐ Yes ☐ No Vascular port

☐ Yes ☐ No Radiation seeds/clips/staples

☐ Yes ☐ No Artificial bone/joint implants

☐ Yes ☐ No Tissue expander

☐ Yes ☐ No Transdermal patch

☐ Yes ☐ No Metallic/foreign body (shrapnel, bullets)

☐ Yes ☐ No Surgical mesh

☐ Yes ☐ No IUD/diaphragm/pessary

☐ Yes ☐ No Other:
_____

☐ Yes ☐ No Body piercings?

If yes, where and when:
_____

***Note: May contain metallic pigments causing heating/tingling; disclose for precautions. ***

Other Safety & Comfort Concerns

☐ Yes ☐ No Eye injury w/metal

☐ Yes ☐ No Claustrophobia/anxiety

☐ Yes ☐ No Mobility limits

☐ Yes ☐ No Have you had an MRI before? If yes, when and where:
_____

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Female Patients ONLY

☐ Yes ☐ No Are you pregnant or possibly pregnant ☐ Yes ☐ No Breastfeeding

MRI Contrast (if planned)

☐ Yes ☐ No Kidney disease/transplant

☐ Yes ☐ No Severe liver disease

☐ Yes ☐ No Recent GFR <6wks

☐ Yes ☐ No Allergy to MRI/CT/contrast? Describe: _____

☐ Yes ☐ No HTN/Diabetes

Remove All Metal Objects

Remove jewelry, piercings, hearing aids, glasses, keys, credit cards, phones, hair items, tools, coins, clothing w/metal.

Patient Signature: _____ Date: _____

Technologist: _____ Date : _____

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MRI PREGNANCY / POTENTIAL PREGNANCY CONSENT & RELEASE FORM (FEMALE PATIENTS)

PATIENT NAME: _____ **DOB**: _____

NOTICE TO PATIENT

MRI uses strong magnetic fields and radiofrequency energy. According to the American College of Radiology (ACR), MRI is generally considered safe during pregnancy, but the long-term effects on the developing fetus are not fully known. Gadolinium contrast is generally avoided in pregnancy unless necessary, as it crosses the placenta and may pose a risk to the fetus.

SCREENING QUESTIONS: **(Initial each that applies)**

☐ _____ I am currently pregnant ☐ _____ I think I may be pregnant ☐ _____ I am not pregnant

If you are pregnant or think you may be pregnant, your MRI will only be performed after a careful risk–benefit assessment.

POTENTIAL RISKS DISCUSSED (Initial each)

☐ _____ The potential risks to the fetus from MRI exposure have been explained.

☐ _____ Gadolinium contrast will not be used unless deemed medically necessary, and risks have been discussed if it is used.

☐ _____ Alternatives to MRI (such as ultrasound or CT) have been explained when applicable.

ACKNOWLEDGEMENT & CONSENT

I have read & understood the above information. I have had the opportunity to ask questions, & all have been answered to my satisfaction. I understand the potential risks & benefits of undergoing an MRI examination during pregnancy or possible pregnancy. I voluntarily agree to proceed with the MRI exam.

RELEASE OF LIABILITY

I release and hold harmless the facility, its staff, and physicians from any claims or liability arising from undergoing this MRI during pregnancy or possible pregnancy, except in cases of gross negligence or willful misconduct.

Patient Signature: _____ **Date**: _____

FACILITY USE ONLY

☐ Risk–benefit assessment completed and documented
☐ Alternative imaging options considered and documented
☐ Gadolinium contrast use approved by ordering physician (if applicable)
☐ Signed consent scanned into patient record

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MRI EMERGENCY CONSENT & LIABILITY WAIVER FORM

Unknown / Non-Identifiable Implant or Device (Orthopedic, Metallic Fragment, or Electronic Device)

PATIENT NAME: _____ **DATE**: _____ **DOB**: _____

NOTICE TO PATIENT

You have an implant or metallic object in your body whose exact type, manufacturer, or MRI safety rating cannot be confirmed. This may include orthopedic hardware, metallic fragments (such as shrapnel), or an electronic device (such as a pacemaker, defibrillator, neurostimulator, or cochlear implant). Because the MRI safety status of this implant/device is unknown, there is some level of risk in proceeding with the MRI exam.

EMERGENCY-ONLY CLAUSE

This MRI examination is being performed under emergency circumstances because the potential benefit to my immediate health outweighs the potential risks. Delaying the MRI could result in serious harm, disability, or death.

POTENTIAL RISKS (**Initial each that applies**)

For Orthopedic Hardware / Metallic Fragment:

☐ _____ Movement or displacement of the object/implant
☐ _____ Heating of the object or surrounding tissue
☐ _____ Distortion of MRI images, affecting diagnosis
☐ _____ Injury to surrounding tissue or organs

For Electronic Implantable Devices:

☐ _____ Device malfunction or unintended activation/deactivation
☐ _____ Heating of device components or leads
☐ _____ Interruption of device function during MRI
☐ _____ Distortion of MRI images, affecting diagnosis

☐ _____ None of the above apply

FACILITY USE ONLY

☐ Risk–benefit assessment completed and documented
☐ Imaging (X-ray/CT) to locate implant/fragment completed
☐ Alternatives discussed and documented
☐ Patient provided verbal explanation of risks
☐ Signed consent scanned into medical record

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MRI EMERGENCY CONSENT & LIABILITY WAIVER FORM (CONTINUED)

Unknown / Non-Identifiable Implant or Device (Orthopedic, Metallic Fragment, or Electronic Device)

ALTERNATIVES

Alternative imaging methods may include CT, ultrasound, or X-ray. In this emergency, these alternatives have been considered and determined not to provide adequate diagnostic information.

ACKNOWLEDGEMENT & CONSENT

I understand the above risks, that the implant/device safety status is unknown, and that this scan is being done for urgent medical reasons. I have had the opportunity to ask questions, and all have been answered. I accept the risks and agree to proceed.

RELEASE OF LIABILITY

I release and hold harmless the facility, its staff, and physicians from any claims or liability for injury or harm that may occur from this MRI, except in cases of gross negligence or willful misconduct.

Patient Signature: _____ **Date**: _____

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Authorization Form

By signing this form, you consent to **Nations Imaging** utilizing and disclosing your health and medical to your attorney, reffering physician and/or the radiologist reading the MRI scan and preparing the read report. This information is for the purpose of treatment and operations related to your health.

Nations Imaging as well as other organizations and individuals such as doctors, hospitals, health plans, are required by law to keep all information related to your health confidential. If you authorize the disclosure of medical information to someone who is not required by law to keep it in such a way, your information may lose the protection provided by the Copyright Act.

MY RIGHTS:
I understand that this authorization is voluntary. Treatment, payment plans, or qualification for benefits may not be conditioned upon the signing of this authorization, except in the following cases. 1) treatments related to medical research. 2) Obtaining information directly related to health plan eligibility. 3) Determination of the obligation of a public or private entity in the payment of a claim 4) To create health information and provide it to a third entity.
I may revoke this authorization at any time, but I must do so in writing and submit such revocation to **California Medical MRI, dba Nations Imaging**, 20 Wilcox St, Ste 111, Castle Rock, CO 80104. Such revocation shall take effect upon receipt by **Nations Imaging**, except to the extent that other persons have acted on the basis of this authorization.
I can obtain a copy of this Authorization.

Please make a selection below:

☐ I authorize **Nations Imaging** to use and disclose my health and medical information provided as defined by state and federal confidentiality laws with my attorney and/or referring physcian.

☐ I do not authorize **Nations Imaging** to use and disclose my health and medical information provided as defined by state and federal privacy laws.

Print Name: _____

Patient Signature: _____

Date: _____

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Authorization for Use or Disclosure of Protected Health Information

Completing this document authorizes this Company to use or disclose health information about you. Failure to provide all information requested may invalidate this Authorization.

Patient Name: _____ **Date of Birth**: _____

Use or Disclosure of PHI

I hereby authorize: California Medical MRI, dba Nations Imaging to release health information described below to the following person or organization:

_____

Name/Title of person to receive information

Information to be Used or Disclosed: (check all that apply)

_____ All health information pertaining to my medical history, mental or physical condition and treatment received.

_____ Only the specific records or types of information set forth below:

____ Assessment/Evaluation ____ Diagnosis _____Medication History
____ Lab Results ____ Treatment _____ Imaging Records

____ Other (Specify): _____

The following information will not be released unless you complete a separate authorization. If you would like to authorize the release of this information, ask Company Staff for the appropriate authorization form.

____ HIV/AIDS test results

____ Psychotherapy Notes

Purpose

The purpose of the requested use or disclosure is (**check all that apply**):

____ Individual's Request _____ Health Care Provider Request

_____ Legal ____Other (Specify): _____

Expiration Date

This authorization is valid for one (1) year from the date of signature.

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My Rights with Respect to This Authorization

I understand that I have the following rights:

- I may refuse to sign this Authorization. My refusal will not affect my ability to obtain treatment, or payment, or eligibility for benefits unless: (i) my treatment is related to research and then I will not be permitted to have treatment without signing this Authorization or (ii) if/when I am receiving health care solely for the purpose of creating information for disclosure to a third party and then I may not receive care unless I sign the Authorization.
- I may inspect or obtain a copy of the health information that I allow the use or disclosure of.
- I have a right to receive a copy of this Authorization.
- I may revoke this Authorization at any time. The revocation must be in writing, signed by me or my personal representative, and delivered, mailed, e-mailed, or faxed to:

  The Company: California Medical MRI, dba Nations Imaging
  Attn: Safety & HIPAA Privacy Officer
  Address: 20 Wilcox St, Ste. 111, Castle Rock, CO 80104
  Office Phone Number: 888-811-1011
  Email Address: safety.compliance@nationsmri.com
- I understand that information disclosed as a result of this Authorization could be redisclosed by the recipient. I understand that if I authorize the disclosure of health information to an individual who is not legally required to keep it confidential, it may no longer be protected by state or federal laws.
- I have read and understand the terms of this Authorization. I have had an opportunity to ask questions about the use and disclosure of my medical information.

Signature: _____ **Date**: _____

If signed by someone other than individual to whom the health information pertains, state the name, relationship, and authority to sign authorization on individual's behalf, and attach any supporting documentation to this request:

Name: _____ **Relationship**: _____

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HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO TIHS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In this notice we use the terms "Company," "we," "us," or "our" to describe **California Medical MRI, dba Nations Imaging.**

I. WHAT IS "PROTECTED HEALTH INFORMATION"?

We are dedicated to maintaining the privacy of your protected health information ("PHI"). PHI is information about you that may be used to identify you (such as your name, social security number or address), and that relates to (a) your past, present or future physical or mental health or condition, (b) the provision of healthcare to you, or (c) your past, present, or future payment for the provision of healthcare. In conducting its business, we may receive and create records containing your PHI. PHI may be in oral, written or electronic form. Examples of PHI include your medical record, claims record, and communications between you and your health care provider about your care. We are required by law to maintain the privacy of your PHI and to provide you with notice of its legal duties and privacy practices with respect to your PHI.

II. ABOUT OUR RESPONSIBILITY TO PROTECT YOUR PHI

By law, we must

1. protect the privacy of your PHI;
2. tell you about your rights and our legal duties with respect to your PHI;
3. notify you if there is a breach of your unsecured PHI; and
4. tell you about our privacy practices and follow our notice currently in effect.

We take these responsibilities seriously and, have put in place administrative safeguards (such as security awareness training and policies and procedures), technical safeguards (such as encryption and passwords), and physical safeguards (such as locked areas and requiring badges) to protect your PHI and, as in the past, we will continue to take appropriate steps to safeguard the privacy of your PHI.

We must abide by the terms of this Notice while it is in effect. This Notice is in effect from the date noted above until we replace it. We reserve the right to change the terms of this Notice at any time, as long as the changes are in compliance with applicable law. If we change the terms of this Notice, the new terms will apply to all PHI that it maintains, including PHI that was created or received before such changes were made. If we change this Notice, we will post the new Notice on our website and will make the new Notice available upon request.

III. HOW WE MAY USE AND DISCLOSE YOUR PHI

Your confidentiality is important to us. Our clinicians and employees are required to maintain the confidentiality of the PHI of our members/patients, and we have policies and procedures and other safeguards to help protect your PHI from improper use and disclosure. Sometimes we are allowed by law to use and disclose certain PHI without your written permission. We briefly describe these uses and disclosures below and give you some examples.

How much PHI is used or disclosed without your written permission will vary depending, for example, on the intended purpose of the use or disclosure. Sometimes we may only need to use or disclose a limited amount of PHI, such as to send you an appointment reminder. At other times, we may need to use or disclose more PHI such as when we are providing clinical treatment.

1) **Treatment, Payment and Healthcare Operations.** Company is permitted to use and disclose your PHI for purposes of (a) treatment, (b) payment and (c) healthcare operations. For example:

- **Treatment.** Company may disclose your PHI to a physician in connection with the provision of treatment to you.
- **Payment.** Company may use and disclose your PHI to your health insurer or health plan in connection with the processing and payment of claims and other charges.
- **Healthcare Operations.** Company may use and disclose your PHI in connection with its healthcare operations, such as providing customer services and conducting quality review assessments. Company may engage third parties to provide various services for Company. If any such third party must have access to your PHI in order to perform its services, Company will require that third party to enter an agreement that binds the third party to the use and disclosure restrictions outlined in this Notice.

2) **Business Associates:** We may contract with business associates to perform certain functions or activities on our behalf, such as payment and health care operations. These business associates must agree to safeguard your PHI.
3) **Appointment Reminders:** We may use your PHI to contact you about appointments for treatment or other health care you may need.
4) **Identity verification:** We may photograph you for identification purposes, storing the photo in your medical record. This is for your protection and safety, but you may opt out.
5) **Authorization.** Company is permitted to use and disclose your PHI upon your written authorization, to the extent such use or disclosure is consistent with your authorization. You may revoke any such authorization at any time.
6) **As Required by Law.** Company may use and disclose your PHI to the extent required by law.
7) **Special Circumstances.** The following categories describe unique circumstances in which Company may use or disclose your PHI, including:
   - **Public Health Activities.** Company may disclose your PHI to public health authorities or other governmental authorities for purposes including preventing and controlling disease, reporting child abuse or neglect, reporting domestic violence and reporting to the Food and Drug Administration regarding the quality, safety and effectiveness of a regulated product or activity. Company may, in certain circumstances disclose PHI to persons who have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition.
   - **Workers' Compensation.** Company may disclose your PHI as authorized by, and to the extent necessary to comply with, workers' compensation programs and other similar programs relating to work-related illnesses or injuries.
   - **Health Oversight Activities.** Company may disclose your PHI to a health oversight agency for authorized activities such as audits, investigations, inspections, licensing and disciplinary actions relating to the healthcare system or government benefit programs.
   - **Judicial and Administrative Proceedings.** Company may disclose your PHI, in certain circumstances, as permitted by applicable law, in response to an order from a court or administrative agency, or in response to a subpoena or discovery request.
   - **Law Enforcement.** Company may, under certain circumstances, disclose your PHI to a law enforcement official, such as for purposes of identifying or locating a suspect, fugitive, material witness or missing person.
   - **Decedents.** Company may, under certain circumstances, disclose PHI to coroners, medical examiners and funeral directors for purposes such as identification, determining the cause of death and fulfilling duties relating to decedents.
   - **Organ Procurement.** Company may, under certain circumstances, use or disclose PHI for the purposes of organ donation and transplantation.

- **Research.** Company may, under certain circumstances, use or disclose PHI that is necessary for research purposes.
- **Threat to Health or Safety.** Company may, under certain circumstances, use or disclose PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.
- **Specialized Government Functions.** Company, may in certain situations, use and disclose PHI of persons who are, or were, in the Armed Forces for purposes such as ensuring proper execution of a military mission or determining entitlement to benefits. Company may also disclose PHI to federal officials for intelligence and national security purposes.

IV. ALL OTHER USES AND DISCLOSURES OF YOUR PHI REQUIRE YOUR PRIOR WRITTEN AUTHORIZATION

Except for those uses and disclosures described above, we will not use or disclose your PHI without your written authorization. Some instances in which we may request your authorization for use or disclosure of PHI are:

1. **Marketing:** We may ask for your authorization in order to provide information about products and services that you may be interested in purchasing or using. Note that marketing communications do not include our contacting you with information about treatment alternatives, prescription drugs you are taking or health-related products or services that we offer or that are available only to our health plan enrollees. Marketing also does not include any face-to-face discussions you may have with your providers about products or services.
2. **Psychotherapy Notes:** On rare occasions, we may ask for your authorization to use and disclose "psychotherapy notes". Federal privacy law defines "psychotherapy notes" very specifically to mean notes made by a mental health professional recording conversations during private or group counseling sessions that are maintained separately from the rest of your medical record.

When your authorization is required and you authorize us to use or disclose your PHI for some purpose, you may revoke that authorization by notifying us in writing at any time. Please note that the revocation will not apply to any authorized use or disclosure of your PHI that took place before we received your revocation.

V. YOUR RIGHTS REGARDING YOUR PHI

This section tells you about your rights regarding your PHI and describes how you can exercise these rights.

1) **Confidential Communication.** You have the right to receive confidential communications of your PHI. You may request that Company communicate with you through alternate means or at an alternate location, and Company will accommodate your reasonable requests. You must submit your request in writing to Company.
2) **Restrictions.** You have the right to request restrictions on certain uses and disclosures of PHI for treatment, payment or healthcare operations. You also have the right to request that Company limits its disclosures of PHI to only certain individuals involved in your care or the payment of your care. You must submit your request in writing to Company. Company is not required to comply with your request. However, if Company agrees to comply with your request, it will be bound by such agreement, except when otherwise required by law or in the event of an emergency.
3) **Inspection and Copies.** You have the right to inspect and copy your PHI. You must submit your request in writing to Company. Company may impose a fee for the costs of copying, mailing, labor and supplies associated with your request. Company may deny your request to inspect and/or copy your PHI in certain limited circumstances. If that occurs, Company will inform you of the reason for the denial, and you may request a review of the denial.
4) **Amendment.** You have a right to request that Company amend your PHI if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is maintained by Company. You must submit your request in writing to Company and provide a reason to support the requested amendment. Company may, under certain circumstances, deny your request by sending you

a written notice of denial. If Company denies your request, you will be permitted to submit a statement of disagreement for inclusion in your records.

5) **Accounting of Disclosures.** You have a right to receive an accounting of all disclosures Company has made of your PHI. However, that right does not include disclosures made for treatment, payment or healthcare operations, disclosures made to you about your treatment, disclosures made pursuant to an authorization, and certain other disclosures. You must submit your request in writing to Company and you must specify the time period involved (which must be for a period of time less than six years from the date of the disclosure). Your first accounting will be free of charge. However, Company may charge you for the costs involved in fulfilling any additional request made within a period of 12 months. Company will inform you of such costs in advance, so that you may withdraw or modify your request to save costs.
6) **Breach Notification.** You have the right to be notified in the event that Company (or a Company Business Associate) discovers a breach of unsecured PHI.
7) **Paper Copy.** You have the right to obtain a paper copy of this Notice from Company at any time upon request. To obtain a paper copy of this notice, please contact Company by calling (888-811-1011).

VI. HOW TO CONTACT US ABOUT THIS NOTICE OR TO COMPLAIN ABOUT OUR PRIVACY PRACTICES

If you have any questions about this notice or want to lodge a complaint about our privacy practices, please write to us at 20 Wilcox St. Ste, 111, Castle Rock, CO 80104. or let us know by calling us at 888-811-1011. You also may notify the secretary of the Department of Health and Human Services.

Please note that we will not take retaliatory action against you if you file a complaint about our privacy practices.

VII. CHANGES TO THIS NOTICE

We may change this notice and our privacy practices at any time, as long as the change is consistent with state and federal law. Any revised notice will apply both to the PHI we already have about you at the time of the change, and any PHI created or received after the change takes effect. If we make an important change to our privacy practices, we will promptly change this notice and make the new notice available on our website at nationsmri.com. Except for changes required by law, we will not implement an important change to our privacy practices before we revise this notice.

VIII. FURTHER INFORMATION

If you would like more information about your privacy rights, please contact us by calling (888)811-1011 and ask to speak to the Safety and HIPAA Privacy Officer. To the extent you are required to send a written request to Nations Imaging to exercise any right described in this Notice, you must submit your request to safety.compliance@nationsmricom.

IX. EFFECTIVE DATE OF THIS NOTICE

This notice is effective March 2026.

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Nations Imaging
Assignment of Benefits Form

Accuracy of Information
All information I have provided to Nations Imaging in connection with the health care services to be rendered to me by Nations Imaging, including without limitation medical, financial, health care benefit plan, employee benefit plan, and insurance coverage, as applicable, is accurate, complete and not misleading. I will promptly inform Nations of any change in the information I have provided.

Financial Responsibility
I have requested health care services from Nations Imaging on behalf of myself and/or my dependents. I understand that by making this request, I become fully financially responsible for any and all charges incurred during the course of authorized treatment. All professional services rendered are charged to the patient and due at time of service. I agree to pay all such charges in full upon presentation of the appropriate statement, unless otherwise agreed upon in advance of treatment. In such cases, required forms will be completed to file for insurance carrier payments.

Assignment of Benefits
I hereby assign and convey to Nations Imaging all medical benefits, insurance payments, and any other payment or reimbursement to which I am entitled for services rendered to me by Nations Imaging. I also authorize and direct my insurer, benefit plan, plan administrator, plan fiduciary, third party administrator, attorneys, agents, and successors in interest to release and disclose to Nations Imaging any insurance policy, description of coverage, benefit plan, explanation of benefits, or other information related to my insurance benefits or other rights promptly upon the request of Nations Imaging. I have designated Nations Imaging as my designated representative, and Nations Imaging is authorized to act on my behalf in accordance with this assignment. I hereby authorize and direct my insurance carrier to issue payment directly to Nations Imaging. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information
I hereby authorize Nations Imaging to: (1) release any information to insurance carriers, regardless of my diagnosis and treatments and as necessary to determine my benefits and insurance coverage for services rendered by Nations Imaging; (2) process insurance claims generated in the course of examination and/or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

Patient/Responsible Party Name: _____

Patient/Responsible Party Signature: _____

Date: _____

ARBITRATION AGREEMENT AND INFORMED CONSENT

Article 1: Agreement to Arbitrate

It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury and instead, are accepting the use of arbitration.

Article 2: All Claims Must Be Arbitrated

It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, and procedural disputes will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers or preceptorship interns who now or in the future treat patient while employed by, working or associated with or serving as back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not. All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the healthcare provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages.

Article 3: Procedures and Applicable Law

A demand for arbitration must be communicated in writing to all parties. The parties shall use their best efforts to agree on an arbitrator. If they cannot agree within sixty (60) days of the demand, each party shall select an arbitrator (party arbitrator) within thirty (30) days and a third arbitrator (neutral arbitrator) shall be selected by the two party arbitrators appointed by the parties within thirty (30) days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of the California Medical Injury Compensation Reform Act ("MICRA") shall apply to disputes within this arbitration agreement, including, but not limited to, sections establishing the right to introduce evidence of any amount payable as a benefit to the patient as allowed by law (Civil Code § 3333.1), the limitation on recovery for non-economic losses (Civil Code § 3333.2), and the right to have a judgment for future damages conformed to periodic payments (CCP § 667.7). The parties further agree that the Commercial Arbitration Rules of the American

Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement. The parties agree that the arbitrator's failure to apply MICRA to the terms of the arbitration is judicially reviewable as an act in excess of the arbitrator's powers.

Article 4: General Provision

All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if: (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation

This agreement may be revoked by written notice delivered to the health care provider within thirty (30) days of signature and if not revoked will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Severability: If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

Article 7: Acknowledgement: Patient has had an opportunity to read and review this agreement and understands all of the information in this agreement. In the case of any pregnant woman, the term "patient" as used herein means both the mother and the mother's expected child or children.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

AGREED:

PATIENT SIGNATURE: _____ **DATE:**_____
IF SIGNED BY SOMEONE OTHER THAN PATIENT, INDICATE NAME AND, RELATIONSHIP*

Name:_____***Relationship:*** _____

***(MUST DEMONSTRATE LEGAL AUTHORITY TO SIGN)**

PRACTICE SIGNATURE: _____ **DATE:** _____

CALIFORNIA MEDICAL MRI
A DIVISION OF NATIONS IMAGING

3760 SANTA ROSALIA DR, LOS ANGELES, CA 90008
20251 VENTURA BLVD, STE D, WOODLAND HILLS, CA 91364
2726 E FLORENCE AVE, HUNTINGTON PARK, CA 90255

(888) 811-1011 documents@nationsmri.com

PATIENT AGREEMENT FORM

Diagnostic Testing Medical Consent

I consent to the administration and performance of all diagnostics procedures which in the judgment of his/her physician/healthcare practitioner is considered necessary and advisable. I also agree that if I decide to leave without receiving treatment and/or without the consent of my physician, then The Diagnostic Imaging Center will not be liable for any consequence of that decision.

Consent to Release of Imaging Records

Original imaging records are the property of The Diagnostic Imaging Center. Upon my request, The Diagnostic Imaging Center will release imaging records to serve my best interest. Once imaging records are released to me as the patient, my referring provider, or an authorized recipient, I understand that I will not hold The Diagnostic Imaging Center liable for all known or unknown claim(s) that may arise should the imaging records become missing or lost. Imaging records may be duplicated at prevailing cost not to exceed $30.00 per CD.

Independent Contractor Notice

The radiologists, technologists, physicians, and other specialized healthcare professionals performing services at The Diagnostic Imaging Center's facilities are independent contractors and are not employees or agents of The Diagnostic Imaging Center. Independent contractors and practitioners are responsible for their own actions. The Diagnostic Imaging Center is not liable for the acts or omissions of any such independent contractors or practitioners.

Release of Information & HIPAA Consent

In order to obtain reimbursement, I understand that portions of my medical record may be disclosed to any person or corporation (or any agent affiliated of such) for all or any portion of charges by The Diagnostic Center for purposes of payment, treatment, or operations as described in the HIPAA Notice of Privacy Practices ("Notice of Privacy Practices"), including, but not limited to insurance companies, health care service plans, workers' compensation carriers, and employers. I hereby acknowledge that a copy of the Notice of Privacy Practices is available in the reception area and that I will be offered a copy of any amended Notice of Privacy Practices at each patient appointment by request.

Assignment of Benefits

For services rendered herein, I hereby authorize that any payment that is made payable to me from my insurance company or responsible financing party will be forwarded to The Diagnostic Imaging Center and its affiliated physicians. Payment shall not exceed The Diagnostic Center's regular charges for treatment. I understand that I am financially responsible to The Diagnostic Imaging Center and its affiliates for charges not covered by my insurance carrier.

Financial Agreement

In consideration of the services provided, I understand and agree that I am held financially responsible (undersigned may be patient, agent or financial responsible party) for all charges, whether or not charges are covered by my insurance. In accordance with the medical insurance policy current rates and terms, all payments and/or balance owed must be forwarded and made payable to The Diagnostic Center. ALL CO-PAYMENTS ARE DUE AND PAYABLE AT THE TIME OF SERVICE. In some cases, a co-payment or patient responsibility may be applied by my insurance company once the claim is processed (i.e., after date of service). I acknowledge and agree that I am financially responsible for all applicable co-payments and patient responsibility payments relating to the services provided. If it is necessary to utilize an attorney to enforce this agreement, or collect any judgment based upon this agreement, then I will be financially responsible and liable for all court costs and attorney fees accrued.

Authorization to Transfer Funds

I understand should a credit balance appear on my account with The Diagnostic Center, then I authorize the use of credit balance to be applied to any unpaid balance due to The Diagnostic Center. Once all claims have been

processed, I may receive a refund from The Diagnostic Imaging Center for any excess of funds that were paid at the time of service prior to submission of claim.

Consent for Acquisition of Medical Records

In order to provide the most accurate reading of my current studies and to assure that I am receiving the highest quality of care, I consent to The Diagnostic Imaging Center obtaining any of my previous images, radiology reports, pathology reports, or results of surgical intervention from outside facilities for comparison to my current studies and/or track abnormal results.

Certification

I certify that I have read, agreed and accepted all the above terms and conditions and I may receive a copy of this agreement upon request.

Patient, or Patient's Agent or Representative: _____

Date: _____

*If patient is a minor, the parent, a legal guardian, or a person authorized by them in writing must sign.

*If patient is incompetent, a legal guardian, a conservator or a person authorized by them in writing must sign.

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TECHNOLOGIST-IN-TRAINING: PATIENT ACKNOWLEDGMENT AND LIMITED LIABILITY WAIVER

PATIENT NAME: _____ **DOB**: _____

NOTICE TO PATIENT
This facility is a training site for MRI technologists-in-training. As part of their clinical education, they may participate in patient procedures under direct supervision by a licensed and certified MRI technologist and/or radiologist.

ACKNOWLEDGMENT AND LIMITED LIABILITY WAIVER

- I understand that an MRI technologist-in-training may assist in or perform aspects of my imaging procedure.
- I understand that all training activity is conducted under the supervision of licensed staff to ensure my safety and compliance with medical standards.
- I consent to receiving services involving a technologist-in-training as part of the MRI process.
- I release and hold harmless the facility, its employees, supervising staff, and the technologist-in-training from any claims or liability arising out of or related to ordinary risks associated with training-based imaging procedures, including but not limited to minor discomfort, extended procedure time, or training-related errors, as long as there is no gross negligence or willful misconduct.
- I understand and acknowledge that this waiver applies to potential personal injury claims arising from the involvement of technologists-in-training, excluding cases involving gross negligence or intentional harm.

GENERAL RISK ACKNOWLEDGMENT
I understand that entering an MRI suite involves exposure to a high-strength magnetic environment and potential physical risks such as tripping hazards, noise exposure, and interaction with specialized equipment. I agree to follow all safety instructions provided by MRI staff and acknowledge these general risks as part of the imaging process.

PATIENT CONSENT
I confirm that I have read this form in its entirety. I have had the opportunity to ask questions and understand the nature of my MRI examination and the role of technologists-in-training. I voluntarily consent to proceed and agree to the terms outlined above.

Patient Signature: _____ **Date:** _____

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PROOF OF CD / COMPROBANTE DE CD

Name / Nombre: _____

Date of birth / fecha de nacimiento: _____

Date of exam / Fecha de examen: _____

Exam/ Examen: **MRI OR XRAYS**

Referring doctor / Doctor de referencia: _____

- I acknowledge I was given a CD with the images at the end of **ALL** my studies. I will be charges a $30 fee for any additional copies or if I lose the CD.
- Yo reconsoco que me entregaron un CD con las imágenes al final de **todos** mis estudios. Se me cobrara $30 por copias adicionales o si lo pierdo.

Patient Signature: _____ **Date**: _____

OFFICE USE ONLY

Technologist / MRI Safety Officer to complete:

☐ Cleared for MRI
☐ Requires further evaluation

- ☐ Unknown/Non-Identifiable Implant or Device
  - ☐ Reviewed and Completed
- ☐ Pregnancy or Potential Pregnancy
  - ☐ Reviewed and Completed
- ☐ MRI contraindicated

Details:

_____

_____

Technologist Name: _____

Technologist Signature: _____ **Date**: _____

Front Desk Initials: _____ **Date**: _____