THE RADIOLOGY CLINIC

PATIENT INFORMATION

Patient Name: _____
First Middle Last

Address: _____
Street / City State / Zip

Date of Birth: _____ **Home Phone:** _____ **Cell Phone:** _____

Referring Physician: _____ **Email:** _____

Gender: _____ **SSN:** _____ How did you hear about us? _____

Ethnicity: □ American Indian or Alaska Native □ Asian □ Black or African American
□ Hawaiian Native or Pacific Islander □ White (Caucasian) □ Other □ Decline to state

Language: □ English □ Spanish □ Other, please specify: _____

PRIMARY INSURANCE INFORMATION

Insurance Name: _____ Policy #: _____ Group#: _____
Policy Holder: _____ Relationship to Patient: _____
Employer: _____ Date of Birth: _____
Address: _____
Street / City State / Zip
Authorization: _____

SECONDARY INSURANCE INFORMATION

Insurance Name: _____ Policy #: _____ Group#: _____
Policy Holder: _____ Relationship to Patient: _____
Employer: _____ Date of Birth: _____
Address: _____
Street / City State / Zip

HIPAA Release of Private Health Information

I authorize the release of any protected health information (PHI) obtained in the course of my registration, examination, and treatment, necessary to file or appeal any claim with my insurance carrier(s) or deemed necessary pursuant to State or federal law, statute, or regulation. Additionally, I authorize The Radiology Clinic to obtain clinical notes from other providers involved in my care in order to submit prospective or retrospective claims to my insurance carrier. I authorize release of my medical records to my provider/physician. I hereby authorize my healthcare provider, insurance carrier, organization, employer, or hospital to release any PHI requested to help interpret my images OR to process a claim and/or bill. I authorize release of any PHI requested by my insurance carrier, health care provider, organization, employer, or hospital for processing claims, bills, or medical record management. I acknowledge that if I wish to have any individual or entity restricted from access to my PHI, I will notify the office in writing. The Radiology Clinic has a comprehensive Notice of Privacy Practices. I acknowledge that I have had the opportunity to review the Notice of Privacy Practices, and have obtained a copy if requested.

By signing below, I acknowledge that I have read, understand, and authorize The Radiology Clinic to use my PHI as outlined in this section related to PHI, and have had the opportunity to ask questions if desired.

Patient/Guardian Signature: _____ Date: _____

Payment of Benefits & Medical Release Authorization

I authorize payment for services rendered, as determined by the company. I understand that I will be responsible for any amount not paid by my insurance carrier or organization funding payment for services. I understand that it is NOT uncommon for insurance carriers to have deductibles and coinsurance responsibility as part of their plan, and that I am financially responsible for such cost sharing as determined by my carrier. I understand that if I have a balance due, which is more than 90 days old, my account will be referred to an outside collection agency, without notice. If my account is sent to collections, I understand that I will be responsible for a 25% collections fee, in addition to my account balance.

By signing below, I hereby acknowledge and accept all terms as listed in this financial responsibility section, and have had the opportunity to ask questions if desired.

Patient/Guardian Signature: _____ Date: _____

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PATIENT INFORMATION

Patient Name: _____ Weight: _____ Height: _____

Referring Physician: _____

Smoking Status: □ Daily □ Occasionally □ Former □ Never

Injury related? □ No □Yes, please specify _____

_____

Please state the reason for your procedure(s) today. What are your symptoms? ***VERY IMPORTANT***

_____ _____
Date Started

Pertinent medical history _____

List previous surgeries and approximate date: _____

_____

Latex Allergy: □ No □ Yes

List current medication(s): □ None _____

Medication Allergies: □ None □ Yes, please specify _____

_____

Personal history of cancer? □ No □ Yes, please specify what type and when? _____

_____

FEMALE PATIENTS ONLY – PLEASE ANSWER THE FOLLOWING QUESTIONS:

1. Are you pregnant or any chance you may be: □ Yes □ No □ Unsure
2. Date of the start of your last period: _____
3. Are you on any type of Birth Control? □ Yes □ No
4. Are you breastfeeding? □ Yes □ No

Besides my physicians, I wish to disclose my protected health information with the persons listed below:

_____ _____
Name Relationship