Park Meadows Imaging

NEW-PATIENT INFORMATION

GENERAL INFORMATION

1. Last Name: _____ First Name:_____MI:__ M ○ F
   Address: _____ City:_____, State:_____ Zip Code: _____
   SSN: _____ DOB: _____/_____/_____
   Please indicate phone number(s) where Park Meadows Imaging staff may leave messages pertaining to appointment times, prescription information, and/or other Private Health Information.
   Home Phone: _____ Msg OK? Y N ○ Emergency Contact: _____
   Work Phone: _____ Msg OK? Y N ○ Relationship: _____
   Cell Phone: _____ Msg OK? Y N ○ Phone: _____
   Email: _____
   What is your preferred method of contact for an appointment reminder? e-mail ○ text ○ voice message

2. **Referring Physician:** _____ **Phone:** _____

3. **Is this visit due to a/an:** __ Auto Accident ○ Work-related injury ○ Other injury ○ No injury
   Date of Injury/onset of symptoms: _____/_____/_____
   (If you are unsure of the exact date, give the best guess of month and year)

4. **Occupation:** _____ **Employer:** _____ **Phone:** _____

INSURANCE INFORMATION

1. **Primary Insurance Company:** _____ Phone#: _____
   Claims_ Address: _____
   ID/Claim#: _____Grp/Policy#:_____ Insured's Name: _____
   Insured's SSN: _____ lnsured's DOB: _____/_____/_____

2. **Other Insurance Company**: _____ Phone#:_____
   Claims_ Address: _____
   ID/Claim#: _____ Grp/Policy#:_____ Insured's Name: _____
   Insured's SSN: _____ lnsured's DOB: _____/_____/_____

3. **Have you retained an attorney or will you be retaining an attorney?** YES ○ NO
   If yes, please provide name, complete address and phone number below.

   Atty Name: _____ Phone#: _____
   Atty Address: _____

I hereby authorize this facility and/or its clinical staff to perform examinations and treatment as necessary for my care.
Patient Signature: _____ Date: _____/_____/_____

_____	_____	_____
Patient Last Name	Patient First Name	MR#

Park Meadows Imaging

CT/IV CONTRAST HISTORY SCREENING

1. Last Name: _____ First Name: _____ Sex: ○ M ○ F

SSN: _____ DOB: ___/___/_____ Height: ___ft. ___inches Weight: _____lbs.

Reason for examination today: _____

Have you had a previous examination related to this problem? Yes __ No __ **When?** _____

Type of study: _____ **Where:** _____

Please answer the questions below to the best of your knowledge. The information will be reviewed by the technologist prior to your examination for screening purposes. This information may also be used by the radiologist in the interpretation of your examination. If you are not sure about your answer please ask the technologist.

Personal History

Asthma	Yes __ No __	Stroke	Yes __ No __
Allergic Respiratory Disease	Yes __ No __	Liver Disease	Yes __ No __
Diabetes	Yes __ No __	Seizure Disorder	Yes __ No __
Kidney Disease	Yes __ No __	Bladder Disease	Yes __ No __
Cancer	Yes __ No __	Headaches	Yes __ No __
Multiple Myeloma	Yes __ No __	Are you pregnant?	Yes __ No __
Prostate Problems	Yes __ No __	Are you breastfeeding?	Yes __ No __
Dizziness	Yes __ No __	Have you been medicated for this exam?	Yes __ No __
Heart Disease	Yes __ No __	Are you taking Glucophage?	Yes __ No __

Have you ever had surgery? Yes __ No __ When? _____ What type? _____

Do you currently take any medications? Yes __ No __ When? _____ What type? _____

Do you have any food/drug allergies? Yes __ No __ When? _____ What type? _____

Have you ever had a previous allergic reaction of x-ray contrast (dye)? Yes __ No __ When? _____ What type? _____

I have answered the above questions to the best of my knowledge and understand the information presented to me.

Patient Signature: _____ ***Date:*** ____/____/_____

Parent/Legal Guardian Signature: _____ ***Date:*** ____/____/_____

Patient Last Name	Patient First Name	MR#

Park Meadows Imaging

RECORD RELEASE/FINANCIAL POLICY/AOB

CONSENT TO RELEASE PATIENT INFORMATION

I hereby authorize the release of medical information including, but not limited to, medical history and physical examination, report of physical findings, x-rays and reports, MRIs and reports, diagnosis, prognosis, independent medical examinations, second opinion examinations, reports obtained from other physicians and providers involved with my medical care, both past and present, narrative reports, medical bills and treatment records and other such documents which may be requested from this office for the purpose of payment of claims, facilitating evaluation and/or treatment, facilitating a continuum of care and treatment, and/or arising out of any claim or action related to any aspect of my medical evaluation and treatment.

I expressly authorize the exchange of records and other documents listed above with any and all health care providers to whom I am referred to during the course of my treatment and/or any health care providers who have previously provided and/or presently provide any health-related services to me whose services may or may not be related to this accident, claim, injury or symptoms including but not limited to my primary care physician, pharmacist, etc.

Patient Signature: _____ ***Date:*** ____/____/_____

Parent/Legal Guardian Signature: _____ ***Date:*** ____/____/_____

FINANCIAL POLICY

It is the policy of Park Meadows Imaging, as a courtesy to you, to file insurance claims with your individual insurance company. You will be responsible for all deductibles, copays, and co-insurance as outlined in your individual contract.

Insurance deductibles and co-insurance amounts must be paid at the time of service, and all patients must pay their co-pay before services are rendered. For those patients who are un-insured or under-insured our cash payment option offers re-priced amounts for services rendered. Payment must be made at the time of service in order to qualify. If payment is not made at the time of service, full usual and customary charges will be billed.

Our billing department will be happy to help you with questions regarding your insurance or payment options, but YOU are ultimately responsible for payment regardless of your insurance coverage. Please check with your insurance carrier prior to receiving services and be aware of any restrictions or clauses that could reduce your benefits such as, second opinions, pre-existing conditions, review for hospital admissions, referrals from your primary care physicians, etc. If you are a member of an HMO or PPO in which Park Meadows Imaging physicians are providers; this does not waive your responsibility to confirm coverage. Your benefits could be significantly reduced for all out-of-network services which become your responsibility and payment required in full, using the cash option outlined above.

When an imaging study has been pre-authorized or pre-certified, this does not guarantee full payment by your insurance company. Please contact your insurance company with any questions.

By my signature, I confirm that I have read and understand the above information; I understand that Park Meadows Imaging, its physicians and/or staff are not responsible for my insurance coverage, pre-authorization, or any other insurance decisions.

Patient Signature: _____ ***Date:*** ____/____/_____

ASSIGNMENT OF BENEFITS

I hereby authorize and direct my insurance company, my attorney, and/or any other individual or entity responsible for the payment of my claims to make payment directly to this office such sums as may be due and owing for medical services rendered to me as well as any other bills that are due to this office. I hereby agree to forward to this office any payment I receive from my insurance carrier within (5) business days of the receipt of payment. I agree to present any payment with the proper endorsement.

Patient Signature: _____ ***Date:*** ____/____/_____

Patient Last Name	Patient First Name	MR#

Park Meadows Imaging

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your NOTICE OF PRIVACY PRACTICES wherein a more detailed description of the uses, examples of and disclosures of my personal health information ("PHI") exists. I understand that this organization has the right to change its NOTICE OF PRIVACY PRACTICES from time to time and that I may contact this office at any time at the address noted on this form if I wish to obtain a current copy of the NOTICE OF PRIVACY PRACTICES.

Patient Name: _____

Name of Authorized Patient Representative if NOT Patient: _____

Relationship of Authorized Patient Representative to Patient: _____

_____ ☐☐/☐☐/_____

Signature of Patient/Authorized Patient Representative *Date*

I certify that I attempted to obtain the signature of the patient and/or authorized representative in acknowledgement on this NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT, but was unable to obtain the patient's signature as indicated below:

- ☐ Patient cannot write due to learning disability/language barrier.
- ☐ Patient was seen on emergency basis and was physically incapacitated and unable to sign name at time of presentation to office.
- ☐ Patient cannot read English and language interpretation was not available.
- ☐ Patient's authorized representative (legal power of attorney, legal parent, legal guardian, etc.) was unavailable to sign.
- ☐ Patient refused to sign NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT stating his/her refusal is due to:

_____

Patient/Authorized Representative was presented with this NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT and refused to sign this document on:

_____ ☐☐/☐☐/_____

Signature of Employee/Witness *Date*

Patient Last Name	Patient First Name	MR#
_____	_____	_____