OUTPATIENT IMAGING

NAME

MRN:

DATE: _____

PATIENT NAME: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

HOME PHONE#: _____ WORK/CELL#: _____

DATE OF BIRTH: _____ AGE: _____ SEX: _____

INSURANCE: _____ MEMBER ID#: _____

POLICY HOLDER: _____ RELATIONSHIP: _____ PHONE#: _____

FOR SELF PAY PATIENTS, HOW WOULD YOU LIKE YOUR REPORT DELIVERED? ☐ MAIL OR ☐ EMAIL: _____

REFERRING PHYSICIAN: _____ ATTORNEY (IF APPLICABLE): _____

MEDICAL HISTORY: Include any history of cancer, chemotherapy, radiation treatment, or steroid injections

_____

PREVIOUS EXAMS: MRI, CT, X-Ray, Nuclear Medicine, Myelogram, Ultrasound

_____

HISTORY OF PREVIOUS SURGERY(S): i.e. Hysterectomy, Appendectomy. Please list type and date.

_____

PATIENT HISTORY:

ARE YOU PREGNANT:	YES____NO____	HIGH BLOOD PRESSURE:	YES____NO____
MYELOMA (BONE CANCER)	YES____NO____	KIDNEY DISEASE:	YES____NO____
ASTHMA:	YES____NO____	HEART DISEASE:	YES____NO____
DIABETES:	YES____NO____	TAKING GLUCOPHAGE?:	YES____NO____
LUNG DISEASE:	YES____NO____	SEIZURE DISORDER:	YES____NO____
BREAST FEEDING:	YES____NO____	HAY FEVER	YES____NO____
PREVIOUS REACTION TO CONTRAST	YES____NO____	TYPE OF REACTION?	

MEDICATION ALLERGIES (PLEASE LIST)

_____

NAME

MRN:

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize OUTPATIENT IMAGING, LLC to use and/or disclose certain protected health information to or for the party or parties listed below:

This authorization permits OUTPATIENT IMAGING, LLC to use or disclose Information and Results relating to the Imaging Studies Performed at OPI.

The purpose of this authorization is to "at the request of the individual", release information to the following Parties/Doctors:

_____

_____

This authorization will expire on 6 years from initial date if signature.

I understand that I have the right to revoke this authorization. I understand that my revocation must be submitted in writing to the Privacy Official at Ten Eastbrook Bend, Peachtree City, GA 30269.

I understand that OUTPATIENT IMAGING, LLC may not condition treatment, payment, enrollment of eligibility for benefits on whether I sign this authorization.

X _____ DATE: _____

PATIENT SIGNATURE

PATIENT ACKNOWLEDGEMENT OF NOTICE OF NOTICE OF PRIVACY PRACTICES

As required by the Privacy Standards of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)
I have received and/or have available a copy of the Notice of Privacy Practices on that date this form is signed. I understand that if any changes are made to this Notice of Privacy Practices, a revised copy will be posted in the office.

X _____ DATE: _____

PATIENT SIGNATURE

PATIENT AUTHORIZATION FOR INSURANCE AND RELEASE OF RECORDS

I authorize the release of any previous results or images in the event OUTPATIENT IMAGING, LLC is in need of them to aid with diagnosis of my procedure today. I permit a copy of this authorization to be used in the place of the original. Furthermore, I have provided OUTPATIENT IMAGING, LLC with true and current insurance information to the best of my knowledge, and I authorize payment directly from the patient's insurance company to Outpatient Imaging, LLC who provide radiology services to me. Where Medicare, Medicaid and Tricare (Champus) benefits apply, I certify that the information given me in applying payment under the Social Security Act is complete and correct and request that payment or authorized benefits be made on the patient's behalf. I authorize Outpatient Imaging, LLC to act as attorney-in-fact to collect and endorse payment checks from any payment source.

X _____ DATE: _____

PATIENT SIGNATURE

OUTPATIENT IMAGING

NAME

MRN:

X _____ DATE: _____

WITNESS SIGNATURRE