



NAME
MRN:
DATE:

PATIENT NAME:

ADDRESS:

CITY/STATE/ZIP:

HOME PHONE#:

WORK/CELL#:

DATE OF BIRTH:

AGE:

SEX:

EMERGENCY CONTACT:

PHONE#:

PRIMARY INSURANCE:

MEMBER ID#:

POLICY HOLDER:

RELATIONSHIP:

POLICY HOLDER DATE OF BIRTH:

POLICY HOLDERS PHONE #:

SECONDARY INSURANCE:

MEMBER ID#:

POLICY HOLDER:

RELATIONSHIP:

POLICY HOLDER DATE OF BIRTH:

POLICY HOLDERS 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.

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:
DATE:

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

INSURANCE WAIVER FOR SELFPAY PATIENTS

I am presenting as a self-pay patient for services and agree that all related charges incurred on this date will be billed to me directly and not any insurance. By signing below, I understand that I will be personally responsible for all charges and that OUTPATIENT IMAGING, LLC will not at any time - currently or in the future - be billing any of these charges to any form of insurance.

X _____ DATE: _____
PATIENT SIGNATURE

X _____ DATE: _____
WITNESS SIGNATURE