A Note to Our Patient:

Your physician will be receiving a copy of your results via fax within two business days. Please contact your physician to go over your results and to obtain a copy of your report. A copy of your report may also be faxed to any physician that you request.

******************************************************************************************************

We do our best to confirm your insurance requirements, however we do advise that you become familiar with your particular plan requirements as well (authorizations, referrals, pre-certifications, etc.). Unpaid amounts become the patient’s responsibility.

If you have a copayment, it is due at the time of service.

******************************************************************************************************

If you require films or CD, kindly give us 48 hour notice or make technologist aware at the time of your study.

- If your physician requires a copy of your images please inform the technologist at the time of your procedure.
- Additional CDs are charged at $5.00 per copy.
- Film is charged at $5.00 per sheet.

A COPY OF YOUR PATIENT RIGHTS IS MADE AVAILABLE TO YOU AT THE TIME OF YOUR VISIT.

(Please refer to the bottom of your clipboard or ask the front desk for a copy).

Signature __________________________________________________________

Date ______________________

If you would like to receive updates from us in the future, please provide your e-mail below:

(Please note: reports and personal information cannot be faxed or e-mailed.)
OPEN MRI AND DIAGNOSTIC IMAGING OF WALL

Have you ever been a patient at this facility?

☐ NO  ☐ YES - When? __________________________

TYPE OF EXAM: ________________________________

ACCOUNT NO. ________________________________

PATIENT INFORMATION

PATIENT NAME (FIRST, LAST)

ADDRESS

CITY

STATE

ZIP CODE

HOME PHONE NO ( )

WORK PHONE NO ( )

DATE OF BIRTH

AGE

SEX ☐ M ☐ F

LMP

SOCIAL SECURITY NO. __________________________

REFERRING PHYSICIAN

PATIENT’S DRIVER’S LICENSE # __________________

ADDRESS

CITY

STATE

ZIP CODE

PHONE NO ( )

HEALTH INSURANCE

PRIMARY

NAME

ADDRESS

CITY

STATE

ZIP CODE

PHONE NO ( )

POLICY NO __________________

GROUP NO __________________

POLICY HOLDER

RELATIONSHIP __________________

SECONDARY

NAME

ADDRESS

CITY

STATE

ZIP CODE

PHONE NO ( )

POLICY NO __________________

GROUP NO __________________

POLICY HOLDER

RELATIONSHIP __________________

AUTHORIZATION

I hereby authorize and direct my insurance carrier to pay directly to OPEN MRI AND DIAGNOSTIC IMAGING OF WALL any benefits due me under my insurance plan. I agree to pay the balance of expenses not paid under this plan. I also authorize OPEN MRI AND DIAGNOSTIC IMAGING OF WALL to release to my insurance company any medical information necessary to process this claim. You are responsible for your co-pay at the time of service.

AUTHORIZED SIGNATURE: ________________________

MEDICAL RECORDS RELEASE

I hereby give permission to contact my physician or Health care facility to obtain prior reports or film/imaging studies relating to prior exam.

PATIENT SIGNATURE: ____________________________

DATE: __________________

PLEASE RETURN THIS FORM TO WINDOW WITH INSURANCE CARD OR FORM  

Thank You
MEANINGFUL USE REQUIRED INFORMATION

Patient ID: ______________________________________________________

Patient Name: ______________________________________________________

Patient DOB: ____________ Height ____________ Weight ____________ Gender M or F (circle one)

Patient Race (check all that apply)
_____Asian             ______ White        ________ Black/African American   ______ Other
_____American Indian/Alaskan Native      ________Native Hawaiian/Pacific Islander

Patient Ethnicity (check one)
____________Hispanic or Latino           ___________Non-Hispanic or Latino

Blood Pressure________________________

Smoking Status (check one)
________Every day smoker ________Current some day smoker______Smoker, current status unknown
________Former smoker______Never smoker______Unknown if ever smoked

Vaccinations (Please check all that you have had)
Flu Vaccination _______    Pneumonia Vaccination _________ Childhood Vaccinations________

Please list any known medical conditions/problems (such as asthma, diabetes, high blood pressure, ETC…) (use back if needed):

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

Please list any known medical conditions/problems (such as asthma, diabetes, high blood pressure, ETC…) (use back if needed):

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

Please list medications currently taken (use back of page if needed):

____________________________________________________________________________________

____________________________________________________________________________________

Please list any known drug allergies (use back of page if needed):

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

Lab Results:  BUN ____________Creatinine ________   EGFR__________

List any Stents, Valves, Pacemakers, Implants, ETC.,

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

Initials: _____________      Date______________
Acknowledgement of “OPEN MRI AND DIAGNOSTIC IMAGING OF WALL” notice of HIPAA Privacy

______________________________   _______________________
Name of Patient                             Date of Birth            Signature of parent/Guardian

Designation of certain relatives, close friends and other caregivers:

I agree that “Open MRI and Diagnostic Imaging of Wall” may disclose certain health information to a family member, close personal friend or other caregivers, since such person is involved with my health care. In that care, “Open MRI and Diagnostic Imaging of Wall” will disclose only information that is directly relevant to the person’s involvement with my healthcare.

I wish to be contacted in the following manner (check all that apply):

Home telephone number: ______________________________________________________
_____ OK to leave message with detailed information*
_____ Leave message with call back number only
_____ OK to mail to my home address as listed on patient registration sheet

Work telephone number: ______________________________________________________
_____ OK to leave message with detailed information*
_____ OK to leave message with call back number

* Detailed information includes and not limited to reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

I designate the following persons listed below as persons involved with my healthcare, for the purpose of the practice making the limited disclosures as described above. I understand that I am not required to list anyone. I also understand that I may change this list at any time.

****PLEASE NOTE**** WE WILL NOT RELEASE INFORMATION TO ANYONE WHO IS NOT LISTED ON THIS FORM

Print Name: ___________________________________________ Relationship to patient: ________________________________

Print Name: ___________________________________________ Relationship to patient: ________________________________

Print Name: ___________________________________________ Relationship to patient: ________________________________

The privacy rule generally requires healthcare providers to take reasonable steps to limit the use of disclosure of, and request for, patient health information to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the patient/parent/guardian. Healthcare entities must keep records of protected health information disclosures. Uses and disclosures for treatment, payment and healthcare operations may be permitted without prior consent.

______________________________    _________________________
Signature of patient/parent/guardian                  Date
PATIENT CONSENT FORM

The Department of Health and Human Services has established a “Privacy Rule” to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients’ consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name: __________________________ Signature: __________________________ Date: __________________________

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To Our Valued Patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule." We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate uses of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients.