CENTRAL IMAGING OF ARLINGTON

3100 Matlock Rd, Suite 105, Arlington, TX 76015
Phone: 817-543-2412

PATIENT INFORMATION **JACKET #:** **PATIENT#**

Last Name: _____ First Name: _____ Age: _____ ☐ Male ☐ Female

Date of Birth: _____/_____/_____ Social Security: _____-_____-_____ Height _____ Weight _____ Marital Status _____

Home Address: _____
(Street # and Name) (Apt) (City) (State) (Zip)

Cell Phone #: _____ Home Phone #_____ Email: _____

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic/Latino

Race: ☐ American Indian/Alaska Native ☐ Black/African American ☐ White/Caucasian ☐ Asian ☐ Native Hawaiian/ Other Pacific Island ☐ Other _____

Nationality: _____ Preferred Language _____ Driver's License/ID # _____ State Issued:____

Emergency Contact Name/Relation: _____ Phone #:_____

REFERRED BY:

Referring Physician: _____ Phone #_____

Primary Care Physician: _____ Phone # _____

INSURANCE INFORMATION (please complete **all** information)

☐ SELF PAY *(Skip to "Medical Background" on next page)* ☐ HMO ☐ PPO ☐ GROUP ☐ OTHER (specify) _____

☐ WORKERS COMPENSATION (WC) and/or ATTORNEY/LOP *(Skip to "Workers Compensation/Attorney Information")*

Insurance Name: _____ Group # _____ Insurance ID # _____

Claim's Address: _____ Phone # _____
(On back of Insurance Card) (On back of Insurance Card)

Responsible Party (Subscriber): ☐ Self *(Skip to "Secondary Insurance")* ☐ Other *(Relationship):* _____

Subscriber/Guarantor's Name: _____ Date of Birth: _____/_____/_____

Subscriber's Social Security: _____-_____-_____ Subscriber's Phone Number: _____

Same Address as listed under Patient Information? ☐ Yes *(Skip to "Secondary Insurance Information")* ☐ No (Please provide address below):

Subscriber/Guarantor's Address: _____
(Street # and Name) (Apt) (City) (State) (Zip)

SECONDARY INSURANCE INFORMATION

☐ NO SECONDARY INSURANCE *(Skip to "Medical Background")* ☐ HMO ☐ PPO ☐ GROUP ☐ OTHER (specify) _____

Insurance Name: _____ Group # _____ Insurance ID # _____

Claim's Address: _____ Phone # _____
(On back of Insurance Card) (On back of Insurance Card)

Responsible Party (Subscriber): ☐ Self *(Skip to "Secondary Insurance")* ☐ Other *(Relationship):* _____

Subscriber/Guarantor's Name: _____ Date of Birth: _____/_____/_____

Subscriber's Social Security: _____-_____-_____ Subscriber's Phone Number: _____

Same Address as listed under Patient Information? ☐ Yes *(Skip to "Medical Background")* ☐ No (Please provide address below):

Subscriber/Guarantor's Address: _____
(Street # and Name) (Apt) (City) (State) (Zip)

WORKERS COMPENSATION/ATTORNEY INFORMATION

Injury result of car accident? ☐ Yes ☐ No Work-related injury? ☐ Yes ☐ No

Workers Compensation/Attorney's Name: _____ Phone # _____

Mailing Address _____ WC Claim # _____

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MEDICAL BACKGROUND

History of Smoking? ☐ Yes ☐ No Do you currently smoke? ☐ Yes ☐ No Packs per day: ____ How Long? _____

Date of Injury: _____ Please check type of accident: ☐ Motor Vehicle ☐ Work Related ☐ Fall ☐ Other

Body location(s) of injury/pain/concern: _____

Briefly explain injury and any problems you are experiencing: _____

_____

_____

Prior x-rays pertaining to this condition? ☐ No ☐ Yes (Specify when and where): _____

Any major medical or surgical history? ☐ No ☐ Yes (Specify): _____

_____

Please indicate if you have or are experiencing:

- ☐ Reaction to any type of contrast/dye used in MRI/CT
- ☐ Cardiac Dysfunction
- ☐ Generalized Severe Debilitation (weakness)
- ☐ Asthma or Allergy
- ☐ Sickle Cell Disease

Signature: _____ **Date:** _____

*****For Female Patients Only***** CONSENT TO PERFORM DIAGNOSTIC IMAGING

Date of Last Menstrual Period _____ Any possibility of Pregnancy? ☐ No ☐ Yes

Any use of Contraceptive? ☐ No ☐ Yes, type: _____ Tubal Ligation? ☐ No ☐ Yes

Hysterectomy? ☐ No ☐ Yes, Partial ☐ Yes, Complete Date of Hysterectomy/Tubal Ligation: _____

PLEASE READ THE FOLLOWING STATEMENT:

The exam your doctor has ordered uses ionizing radiation which may be harmful to an unborn child. The possibility of health effects depends on the gestational age of the unborn baby at the time of exposure and the amount of radiation exposure.

I, *(PRINT NAME)* _____, understand that if I am pregnant and have examinations that use radiation, it is possible to injure the fetus. I have been advised that the ten days following onset of menstrual period are considered to be safe for exams involving radiation.

With the full understanding of the above, I do hereby state to the best of my knowledge *(initials)*:

_____ **I am not** pregnant nor is pregnancy suspected or confirmed at this time and I wish to have the examination performed now.

_____ **I am** pregnant or may possibly be pregnant **and wish to proceed with the examination despite health risks to the unborn child.**

_____ **I am** pregnant or may possibly be pregnant and **wish to decline** the examinations due to health risks to the unborn child.

Signature: _____ **Date:** _____

Technologist Signature: _____ Date: _____

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PATIENT CONSENT AND ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I understand that as part of the provision of health services, Central Imaging of Arlington creates and maintains health records and other information describing, among other things, my clinical history, symptoms, examination, results, diagnoses, treatment, radiology films and images, and any plans for further care of treatment.

I have been provided with a Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that Central Imaging of Arlington reserves the right to change their Notice and practices and, prior to implementation, will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations (quality assessment and improvement activities, underwriting premium rating, conducting or arranging for medical review, legal services, and auditing functions, etc.) and that Central Imaging of Arlington is not required to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment, and healthcare operations. I have the right to revoke this consent, in writing, except where disclosures have already been made in reliance on my prior consent.

This consent is given freely with the understanding that:

1. Any and all records, whether written, oral, or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment of healthcare operations without my prior written authorization, except as otherwise provided by law
2. A photocopy or fax of this consent is as valid as the original.
3. I have the right to request that the use of my protected health information, which is used or disclosed for the purposes of treatment or payment of healthcare operations, be restricted. I also understand that Central Imaging of Arlington and I must agree to any restriction in writing that I request on the use and disclosure of my protected health information; and agree to terminate any restrictions in writing on the use and disclosure of my protected health information which have been previously agreed upon.

Signature of Patient _____ **Date Signed** _____

Patient's Printed Name _____ **Social Security Number** ___-___-___ **Date of Birth** _____

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AUTHORIZATION FORM FOR RELEASE/RECEIPT OF PROTECTED HEALTH INFORMATION

I,_____,D.O.B._____,SS#_____
(PRINT NAME)

hereby authorize **Central Imaging of Arlington** ("practice") to use, receive, and/or disclose the protected health information for billing and other purposes.

The person and/or facility to whom the information will be released to or received from:

_____
(Spouse, family or Friend Name of Individual)

_____
(Spouse, family or Friend Name of Individual)

_____
(Spouse, family or Friend Name of Individual)

Central Imaging of Arlington is hereby authorized to receive and/or disclose to the aforementioned person and/or facility and the aforementioned person and/or facility is hereby authorized to use or disclose the information. This authorization shall be in force and effective for **one year from the date signed below.**

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the owner **Dr. Phyllis Frostenson at Central Imaging of Arlington at P.O. Box 150268, Arlington, Texas 76015**. I understand that a revocation is not effective to the extent that the practice has relied on this authorization in its action. Also, a revocation is not effective if this authorization was obtained as a condition of obtaining insurance coverage, as other law provides the insurer with the right to contest a claim under the policy or the policy itself.

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal HIPAA privacy regulations.

Central Imaging of Arlington will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

_____ _____
Signature of Patient or Personal Representative **Date**

_____ _____
Printed Name of Patient or Personal Representative **Description of Personal Representative's Authority**