Riverside Imaging Specialists
Registration and Medical Information Release

FIRST NAME (Please Print)	MIDDLE INITIAL	LAST NAME

STREET ADDRESS **CITY/STATE/ZIP**

CONTACT NUMBER: primary ( ) _____ secondary ( ) _____

SS# **BIRTHDATE** **GENDER (M / F)**

RELATIONSHIP TO SUBSCRIBER: _____SELF _____SPOUSE _____CHILD _____OTHER

MARITAL STATUS: _____SINGLE _____MARRIED _____DIVORCED _____WIDOWED

INFORMATION FOR SELF

Employer:	**Spouse:**
Employer Address:	**Spouse DOB:**
City/State/Zip:	**Spouse Employer:**
Phone Number:	**Employer Address:**
	City/State/Zip:
	Phone Number:

GUARANTOR INFORMATION

Last Name	**First Name**	**Middle Initial**
Mailing Address	**City/State/Zip**	
Phone Number:	**Relationship to Patient**	
Social Security Number	**Date of Birth**	

Please Initial Below

_____I request that this facility render medical services to me.

_____I understand that I am fully responsible for payment of all charges resulting from such authorized medical treatment, and that such charges are due and payable at the time of service unless I have made other arrangements regarding a fee payment schedule.

_____I authorize this facility to release information regarding my MRI/CT and or my medical condition and treatment to my insurance company, physician, attorney and/or other healthcare professionals involved in my medical care. I hereby release this facility from all legal responsibility or liability that may arise from the act I have authorized.

_____ I hereby authorize this facility to obtain any medical records and/or reports from my physician, hospital or other facility. This information is to be used for comparison, as well as my diagnosis.

_____I authorize payment of benefits from my insurance coverage directly to this facility.

Signature:_____ Date:_____

CT PATIENT SCREENING FORM Patient ID Number: _____

NAME: _____ DATE:_____
DATE OF BIRTH: _____ AGE: _____ GENDER:_____ WEIGHT:_____

PLEASE ANSWER THE FOLLOWING QUESTIONS:
What complaint/symptom led you to see your doctor for him/her to order this scan today?

_____

_____

How long have you had your symptoms?

_____

Do you have diabetes? YES NO
Do you have a history of kidney disease? YES NO
If YES, are you on dialysis? YES NO Next scheduled dialysis _____

Do you have a personal history of cancer? YES NO **Type & Date** diagnosed:_____
Chemotherapy: YES NO
Radiation: YES NO

Please indicate any medication allergies:

_____

Are you allergic to IODINE or IV CONTRAST DYE? YES NO
Have you previously been injected with x-ray dye for exams, such as CT or IVP's? YES NO

Are you pregnant or breastfeeding? YES NO If yes, please notify office staff
Do you have a history of a stroke? YES NO
Do you have asthma, COPD or emphysema? YES NO Please **CIRCLE** which one.
Have you ever been diagnosed with COVID-19? YES NO If yes, when? (month & year) _____
Are you a smoker? YES NO **If yes**, how many years____ packs a day_____
If you have quit, how long ago? _____

Please **list previous surgeries** only to the body part we are scanning today. Please include the **year** of the surgery if known.

_____

_____

I understand I will be receiving x-rays and hereby release all radiologists, respective staff and the facility thereof, of any and all responsibility for any adverse reaction to myself.
I attest that the above information is correct to the best of my knowledge. I have read and understand the entire contents of this form and I have had the opportunity to ask questions regarding the information on this form.

Patient/Guardian signature: _____ Date: _____

AUTHORIZATION TO RELEASE
MEDICAL INFORMATION
TO INDIVIDUALS/FAMILY MEMBERS

Patient Name: _____

I the named patient above fully authorize Riverside Imaging Specialists, to disclose and use my protected health information related to my imaging procedure, to any healthcare provider treating me or involved in my current diagnosis or treatment.

Additionally, any one or all the following individuals listed below may have complete access to my health information, medical records and account records:

_____

Name **Relationship to Patient**

_____

Name **Relationship to Patient**

_____

Name **Relationship to Patient**

RECEIPT AND ACKNOWLEDGEMENT OF PRIVACY PRACTICES

_____ *By check mark*, I agree and acknowledge that I have reviewed a copy of a Notice of Privacy Practices concerning Protected Health Information.

_____ *If marked by X*, I acknowledge receipt of this Notice of Privacy Practices, but choose not to read this information regarding my Protected Health Information.

_____ _____

Signature of Patient or Patient's Legal Representative (if applicable) **Date**

RIVERSIDE IMAGING SPECIALISTS, LLC

YOUR HEALTH INFORMATION AND PRIVACY

WE RESPECT AND SAFEGUARD YOUR PRIVACY AND HEALTH INFORMATION

- Federal Law protects and outlines who may see and receive your protected health information (PHI).

- Providers, facilities, employer group plans, Medicare, Medicaid and other insurance companies all must follow the laws regarding PHI.

- Information, conversations, billing information, and information kept and contained in computers systems is all protected under the law.

- Your rights over the use and confidentiality of your PHI provide that, you may get copies of your health records, request corrections to your PHI, receive notice as to how your information may be used, decide if you will allow your information may be used or shared for other purposes such as marketing, get reports on when and why your PHI was shared and with whom.

- If you believe your rights have been denied or isn't being protected your may file a complaint with your provider, health care insurer, or the U.S. government. To do so you may go online to the website below:
  www.hhs.gov/ocr/hippa/ or call 1-866-627-7748 toll free.

YOUR INFORMATION MAY BE USED FOR:

- Your treatment and care and the coordination of same.
- To pay hospitals, clinics, doctors, imaging facilities and other providers of care to help in running their businesses.
- To protect the health of the general public in the case of communicable diseases.
- To make sure doctors and other providers give proper care and that police receive vital information about such incidents such as gunshot wounds or similar physical trauma.
- To share PHI including health care bills with designated immediate family members or other relatives, friends, or others you identify that may be involved in your health care, unless you object.

WE MAY NOT USE YOUR PHI UNLESS YOU GIVE WRITTEN PERMISSION UNLESS THE LAW ALLOWS. WITHOUT YOU AUTHORIZATION WE CANNOT SHARE YOUR PHI WITH YOUR EMPLOYER, OR FOR ANY PURPOSE SUCH AS MARKETING OR ADVERTISING.
WE MAY NOT SHARE ANY MENTAL HEALTH OR COUNSELING INFORMATION.

THE LAW ALSO PROTECTS YOUR HEALTH INFORMATION BY REQUIRING HEALTH CARE PROVIDERS AND INSURERS TO TEACH PEOPLE HOW YOUR PHI MAY BE USED AND TO KEEP IT SECURE.

YOU MAY OBTAIN MOR INFORMATION BY CONTACTING THE MANAGER AT 478-745-6747 OR EMAILING: THE MANAGER at the web address jessica@riverside-imaging.com.