Welcome to Arista Medical Imaging!

PATIENT INFORMATION

Name: _____ SS # _____
Last Name First Name MI

Email: _____

Address: _____ City: _____ State: _____ Zip: _____

Sex: ☐ M ☐ F Age: _____ Birth date: _____ Marital Status: _____

Patient Phone: (____)_____ Patient Work: (____)_____ Patient Cell: (____)_____

Employer: _____ Occupation: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact: _____ Phone (_____)_____ Relationship: _____

REFERRING PHYSICIAN INFORMATION

Referring Physician: _____ _____ Phone #: _____ Fax #: _____

Address: _____ City: _____ State: _____ Zip: _____

Type of Exam __ _____

INSURANCE INFORMATION

Primary Company _____ Telephone (_____)_____

Contract # _____ Group # _____ Eff. Date: _____ Thru: _____

Claim Address _____ City _____ Zip: _____

Insured: _____ DOB: _____ _____ SSN: _____ Relationship: _____

Secondary Company _____ Telephone (_____)_____

Contract # _____ Group # _____ Eff. Date: _____ Thru: _____

Claim Address _____ City _____ Zip _____

Insured: _____ DOB: _____ _____ SSN: _____ Relationship: _____

ARE YOU GETTING THIS SCAN DONE DUE TO AN AUTO ACCIDENT OR JOB INJURY?

YES ☐ NO ☐

IF SO, WHAT IS THE DATE OF THE INJURY/ACCIDENT _____

***I UNDERSTAND THAT MY REPORT WILL BE RELEASED TO MY REFERRING PHYSICIAN.

I WILL NEED TO CONTACT MY PHYSICIAN IN ORDER TO RECEIVE AND/OR REVIEW THIS REPORT.*******

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

PATIENT MEDICAL HISTORY FORM	ARISTA MESA	DATE:

PATIENT INFORMATION

Last Name:	First Name:	Chart #:

Birth Date:	Sex: Male ☐ / Female ☐	Height:	Weight:

PATIENT HISTORY AND SAFETY QUESTIONS | Physician Name: | Films for Pt or Dr?

- Metallic Clips or Implants? ☐ Yes ☐ No
- If yes, explain _____
- Have you had any heart surgery? ☐ Yes ☐ No
  - If yes, explain _____
- Have you had any brain surgery? ☐ Yes ☐ No
  - If yes, explain _____
- Cardiac Pacemaker? ☐ Yes ☐ No
- Drug Infusion Device/Pump? ☐ Yes ☐ No
- If yes, explain _____
- Internal Hearing Aid? ☐ Yes ☐ No
- Have you worked with metal? ☐ Yes ☐ No
  - If yes, were orbital Xrays obtained? ☐ Yes ☐ No
- Any foreign objects in eyes? ☐ Yes ☐ No
- Any chance of pregnancy? ☐ Yes ☐ No
- Are you claustrophobic? ☐ Yes ☐ No

- Any medications for area being scanned? ☐ Yes ☐ No
- Any previous surgery in area being scanned? ☐ Yes ☐ No
  - If yes, when? _____
- Is surgery planned? ☐ Yes ☐ No
  - If yes, when? _____
- Do you have any history of cancer? ☐ Yes ☐ No
  - If yes, year and type diagnosed _____
- Is there any history of trauma in region? ☐ Yes ☐ No
  - If yes, explain _____
- Any previous CT or MRI scans? ☐ Yes ☐ No
  - If yes, what was performed? _____
  - When & Where? _____
  - Results: _____
- Do you have permanent eyeliner? ☐ Yes ☐ No
- Do you have stents in your body? ☐ Yes ☐ No
- Do you have an artificial heart valve? ☐ Yes ☐ No

Additional Comments / Complaints:

_____

_____

Body Part Scanned	Estimated time of scan	Pt Initials	Tech Initials
1) -------			
2) -------			
3) -------			
4) -------			

I hereby agree that the information above is true and accurate.

Patient Signature:_____ Guardian Signature:_____

TECHNOLOGIST COMMENTS:

_____

_____ **Technologist:**_____

ASSIGNMENT OF BENEFITS & PRIVACY FORM

ASSIGNMENT OF BENEFITS

Patient Name:	Social Security Number:
Insurance:	

I hereby instruct and direct the above named Insurance Company to pay by check, made out to Arista Imaging LLC, and mailed to PO Box 1169 Rockland ME 04841, the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. This is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness to the above mentioned assignee and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this assignment shall be considered effective and as valid as the original.

Signature of Patient: _____ Date: _____

Signature of Witness: _____

PRIVACY & ADDITIONAL AUTHORIZATIONS

- I hereby give consent for treatment, consultation, or testing as necessary.
- I authorize the release of any information to any insurance company, attorney, third party billing company, or any necessary organization for the purpose of reimbursement for any procedures performed.
- I authorize the release of any pertinent health information to my personal physician or any consulting physician.
- I understand that if more than one anatomical region is scanned or if a contrast agent is required by my physician, additional charges will be incurred.
- I understand and agree that I am ultimately responsible for the balance on my account for any services rendered. A service charge of 1.5 % per month (18%) per year will be added to any balance due more than 30 days beyond the date of my first statement. 30% will be added to my balance to compensate for legal/collection fees.
- I have provided and read all of the above information requested.
- I certify that this information is true and correct to the best of my knowledge
- I will notify you of any changes in my health status or the above information.

Signature of Patient: _____ Date: _____

Signature of Witness: _____ Date: _____

Interviewer: _____ Date: _____

HIPAA PRIVACY FORM	Site: Arista Mesa
Patient Name:	

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review carefully.

Our responsibility to you:

- We have a duty to maintain the privacy of your medical information and provide you with this notice of our legal duties and practices.
- We are responsible for abiding by the current terms of this notice.
- We are responsible for providing our patients with a notice of any changes to or revisions of this notice of privacy practices.
- We are responsible for maintaining documentation of privacy notices and written acknowledgments for a period of six years from the date of creation of the date last in effect, whichever is later.

How we may use and disclose health information about you:

- We may use and disclose medical information about you for treatment (by sending medical information about your radiology procedure to another physician involved in your care as part of a referral), to obtain payment for your treatment (sending billing information to your insurance company or Medicare), and to support health care operations (such ass comparing patient data to improve our quality of care).
- We may disclose medical information about you to our business partners that provide use with administrative support rendering your care. These business partners are required by law to comply with the provisions of federal privacy laws (under HIPAA) and give you the same protections we do.
- We may also use or disclose your medical information for several other purposes. Subject to certain requirements we may give out medical information about you for public health purposes, abuse or neglect reporting, health oversight audits or inspections, research studies, workers compensation purposes, and emergencies. We also will disclose medical information when require to by law, such as in response to a request from law enforcement in specific circumstances, or in response to a valid judicial or administrative order.
- We may contact you for appointment reminders, or to tell you about or recommend possible treatment options, alternatives, health-related benefits, or services that may be of use to you.
- In any other situation not covered by this notice we will ask for your written authorization before using or disclosing medical information about you. If you choose to authorize use or disclosure, you can later revoke that authorization by notifying us in writing of your decision.

Your rights regarding your medical information:

- You have the right to review and obtain a copy of medical information that we use to document your care by submitting a written request. A charge may be assessed to offset the cost of making copies.
- You have the right to request that we correct your records by submitting a request in writing that provides your reason for requesting the correction.
- You have a right to a list of instances where we have disclosed medical information about you with these exceptions: treatment, payment, healthcare operations, or per your written request. The request must state the time periods desired and cannot precede the date of April 14, 2003, when the law became effective.
- You have the right to be provided with a paper copy of this notice for your own use if you so request.

Complaints:

- If you are concerned that your privacy rights may have been violated, or if you disagree with a decision we made about your records, you may contact the Privacy Officer of this institution.
- You may also send a written complaint to the U.S. Department of Health and Human Services Office of Civil Rights.
- Under no circumstances will you be penalized or retaliated against for filing a complaint.

Patient Signature:_____ Date:_____

1345 E McKELLIPS RD
MESA, ARIZONA 85203
PHONE: (480) 644-9878
FAX: (480) 644-9879

RELEASE OF FILMS

DATE: _____

I, _____ hereby acknowledge that I am receiving a copy of my MRI films from the scan that was performed on, _____.

I also acknowledge that if I need films/ CD in the future, there will be a cost incurred to me in the amount of **$8.00 per sheet of film or $5.00 per CD.**

Patient Signature: _____

Witness Signature: _____

Film Delivery Slip

Patient's Name: _____

Name of Office Delivering to: _____

Signature of Receiving Office: _____

Date and Time: _____