PATIENT MEDICAL QUESTIONNAIRE

NAME: _____

DATE OF BIRTH: _____ GENDER: _____ HEIGHT: _____ WEIGHT: _____

DESCRIBE YOUR SYMPTOMS: _____

WAS THIS DUE TO AN ACCIDENT? _____ DATE OF INJURY: _____

LIST DRUG ALLERGIES, INCLUDING MRI & CT DYE/CONTRAST: _____

LIST CURRENT MEDICATIONS: _____

_____

LIST PREVIOUS SURGERIES: _____

DO YOU HAVE ANY METAL/NON-METAL IMPLANTS? ___ YES ___ NO IF YES, WHAT TYPE? _____

PERSONAL HISTORY OF CANCER? ___ YES ___ NO IF YES, WHAT TYPE? _____

RELATED TO YOUR APPOINTMENT TODAY, IN THE LAST 3 YEARS HAVE YOU HAD ANY OF THE FOLLOWING: (CHECK ALL THAT APPLY)

___MRI ___CT ___XRAY ___ULTRASOUND ___NUCLEAR MEDICINE ___PETSCAN ___MYELOGRAM ___ARTHROGRAM

FACILITY & LOCATION: _____ **BODY PART:** _____

PLEASE CHECK YES OR NO TO ALL OF THE FOLLOWING:

	YES	NO		YES	NO
ARE YOU CLAUSTROPHOBIC?			HIP/JOINT REPLACEMENT		
PACEMAKER			GUNSHOT WOUND/SHRAPNEL		
DEFIBRILLATOR			TATTOO/TATTOO EYELINER		
NEUROSTIMULATOR			HAVE YOU WORKED AS A WELDER?		
PAIN PUMP/INSULIN PUMP			IF YES, DID YOU WEAR EYE PROTECTION?		
STENT/SHUNT			ARE YOU 60 YEARS OR OLDER?		
ANEURYSM CLIP			DIABETES		
TISSUE EXPANDER			HYPERTENSION		
COCHLEAR IMPLANT			HEART PROBLEMS		
HEARING AIDS			LIVER PROBLEMS		
PROSTHETIC VALVE			KIDNEY PROBLEMS		
EAR/EYE PROSTHESIS			ARE YOU ON DIALYSIS?		
HEART/BRAIN SURGERY			MULTIPLE MYELOMA		
MEDICINE PATCH(S)			COLLAGEN VASCULAR DISEASE		

OFFICE USE ONLY:

W# _____

PAGED: _____

SCANTIME: _____

P/U: _____

IV ROOM: _____

IV DONE: _____

B / G : _____

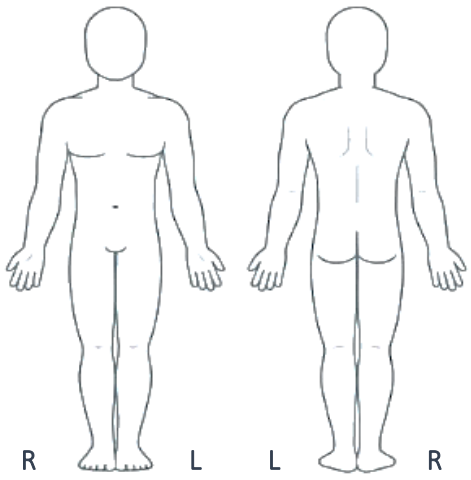
CREA: _____

GFR: _____

LOT# _____

EXP: _____

SHADE THE APPROPRIATE BODY PART AND CHECK THE SYMPTOM(S):



- ☐ **ACHE**
- ☐ **BURNING**
- ☐ **NUMBNESS**
- ☐ **PINS AND NEEDLES**
- ☐ **STABBING**
- ☐ **TINGLING**
- ☐ **WEAKNESS**

OFFICE USE ONLY
APPOINTMENT ALERTS/NOTES:
PROTOCOL/TECH NOTES:

MY FOLLOW-UP
IS SCHEDULED ON: _____

CONSENT FOR TREATMENT: I certify that the above information is true and correct to the best of my knowledge. I consent and authorize Crown Imaging to complete the exam(s) ordered by my referring physician within the standards set by the supervising radiologist.

PATIENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

CROWN IMAGING

Patient Registration and Authorization

PATIENT NAME		
DATE OF BIRTH	SEX	SSN#
ADDRESS (**STREET**, **CITY**, **STATE**, **ZIP**)		
PRIMARY PHONE #	SECONDARY PHONE #	TERTIARY PHONE #
EMAIL		
EMERGENCY CONTACT		PHONE #
PRIMARY INSURANCE	POLICY #	GROUP #
SECONDARY INSURANCE	POLICY #	GROUP #

ESTIMATION OF BENEFITS: The amount due at the time of service is calculated based on a review of benefits provided to **Crown Imaging** by my insurance company. I understand that **this is an estimate** and is subject to change given my insurance's final consideration of the claim. Once the claim has been processed, I may receive a statement of any balance or refund.

_____INITIAL

RADIOLOGY BILL: I understand that the radiologist bills separately for my exam(s) and I may receive a separate bill from one of the following radiology groups: **Radiology Associates of North Texas (RANT)** or **Texas Radiology Associates (TRA).**

_____INITIAL

ASSIGNMENT OF BENEFITS AND PAYMENT: I assign and authorize payment of all benefits payable to **Crown Imaging/RANT/TRA** for services rendered to me or my dependent. I understand that I am responsible for any health insurance deductibles, copayments, and coinsurance. Should my insurance company deny my claim for any reason, I will assume responsibility for the claim.

I authorize **Crown Imaging** to release any medical information compiled in my medical records to any organization or healthcare operation which is or may be liable for payment of charges associated with the services rendered for all other purposes of payment of claims.

_____INITIAL

MEDICAL RELEASE: I understand that my referring physician will automatically receive my radiology report within 24-48 hours after my exam(s) and will also be given a copy of the images **if requested**. If for any reason I need an additional copy of my images, I will need to request them 24 hours in advance and additional fee may be required.

In addition to my referring physician, I authorize Crown Imaging to release my medical records to the following individual(s), facility, or entity. I understand that Crown Imaging will provide this information within 15 days from receipt of request. (Please include any persons responsible for picking up records or images)

1: _____

2. _____

3. _____

_____INITIAL

By signing below, I acknowledge that I have read, understand, and consent to all policies stated above.

_____ _____

Patient/Legal Guardian Signature **Date**

CROWN IMAGING

Notice of Privacy Practices

To our patients:

This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following important information:

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

Your rights regarding your health information

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or healthcare operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment of your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records. There may be circumstances, when we must get permission from your referring doctor before releasing your report(s) to you, or to another doctor you are requesting. A Medical Release will also need to be filled out by you for each request.
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Crown Imaging Center – Walnut Hill. You must provide us with a reason that supports your request for amendment.
5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this notice at any time. To obtain a copy of this notice, contact our front desk personnel.
6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact Crown Imaging Center's business office at (972) 759-5140.

By signing below, I confirm that I have read and understand the above statement and policies.

Patient Signature: _____ Date: _____