diagnostichealth
Reading

Office Use Only
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PATIENT INTAKE FORM

PATIENT INFORMATION

Patient MRN: ________________

Last Name: ______________________ First Name: ______________________ MI: ______ Gender: M / F

Marital Status: Single Married Divorced Widowed DOB: ______________ SSN: ______-______-__________

Address: ______________________________ City: ______________________ State: ______ Zip: ________

Home Ph: ______- ______- _________ Mobile/Other: _____- _____- _________ Date of onset of pain or injury: ____________

PATIENT EMPLOYER INFORMATION

Status: Full-Time Part-Time Un-Employed Student Disabled Retired

Employer: ______________________________ Work Phone: ________- ________- __________ Ext: __________

Employer Address: ____

PATIENT EMERGENCY INFO

Name: ______________________ Phone: _____-_____-_________ Relationship to patient ______________

RESPONSIBLE PARTY (Complete if patient is under 18yrs old)

Name: ______________________ SSN: _____ - ___ - _______ DOB: _________ Relationship to Patient ___________

Address (if different from patient): ____

PRIMARY INSURANCE INFORMATION

Insured Name: ______________________ **DOB:** ____________ **Relationship to Patient:** ____________

Insurance: ______________________ Ph #: ______________________ IN NETWORK? Y N

Subscriber **ID** / Policy # ______________________ Group # ___________ Eff: _________ Ins Rep Name: ____________

Co-Pay / Co-Ins / Deductible Amount: ______________________ Out-of-Pocket: ______________ Reached? Y / N

Authorization/Pre-Cert: Y / N # ______________________ Eff Date: ____________ Exp: ______________

Company Name & Address: ____

____

WC/On the Job Injury: Y / N **MVA(Auto):** Y / N Date of Accident/Injury: ______________ State accident occurred: _____

WC/AUTO Company Name ______________________ Adjuster name and Phone ______________________

WC/AUTO Claim # ______________________ Authorization for treatment: Y N - for BODY part: ______________

Current Coverage? Y / N CLAIM CAP AMT: DATE VERIFIED: DH initials:

SECONDARY INSURANCE INFORMATION

Insured Name: ______________________ DOB: ____________ Relationship to Patient: ____________

Insurance Company Name & Address: ______________________ Ph #: ______________________

____

PATIENT CONSENT

I have reviewed the above information and verify it is accurate.

Patient Signature: ____ Date: ____________

DH Witness Signature: ____ Date: ____________

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Office use only: **PHYSICIAN ORDER (Verbal only)**

Ordering Physician: ______________________ Caller Name: ______________________

Verbal Order / Procedure(s): ______________________ Date: ______________

Signs & Symptoms **(No Rule Out)**: ______________________

Verbal Order Received By: ______________________

ASSIGNMENT OF BENEFITS AND FINANCIAL AGREEMENT

I understand if I have provided complete and accurate insurance information, Diagnostic Health, Reading (DH) will file both my primary and secondary insurance. I understand based on the agreement DH has with my insurance network and information they have received at the time of verification my co-pay/self-pay/deductible amount due today is $______________. I also agree to be responsible for any additional co-share and/or non-paid amounts identified by my insurance after my claim has been processed. In the event legal action should become necessary, I agree to be financially responsible for all collection, attorney and court fees incurred.

I understand if the services provided today are being represented by an attorney, auto insurance and or third party payor, I am financially responsible for all charges incurred.

I authorize DH to release to my insurance company any medical information which may be necessary for processing my insurance claim. I also assign "benefits payable to" for my services today to Diagnostic Health.

I further authorize the release of any medical information in regard to the services which are provided by DH to any physician or health care provider by whom I have been or will be treated who request such information.

Scheduled Procedure(s): ______________________

Patient/Guardian Signature: ______________________ Date: ______________

DH Representative Signature: ______________________ Date: ______________

MEDICAL RECORDS AUTHORIZATION TO DISCLOSE

I authorize the disclosure of my medical records/information (individuality identifiable health information) to the persons listed below. I understand this is a voluntary request to release my health information to someone other than healthcare providers. I understand **only** the individuals identified below are authorized to receive copies, pick up my medical records or inquire about my account at Diagnostic Health, Reading (this includes my spouse, parents, family members, friends, children etc.). I also understand identification confirmation for any requesting individual will be confirmed and documented prior to the release of my record information.

1 ______________________ 2 ______________________ 3 ______________________

- Can DH leave information related to your account, appointment and or any other medical record information on your answering machine or voicemail? YES or NO (please circle)

I understand this Medical Records Authorization to Disclosure will expire SIX years from today. I understand I can revoke this authorization at any time by notifying DH in writing. If I revoke this authorization, DH will not be liable for any release of records completed prior to my change of this authorization. My signature below confirms that I understand and agree to the above statements regarding Medical Records Authorization to Disclose.

______________________ ______________

Signature of patient, responsible party or patient's representative Date

______________________ ______________

Printed name for patient's representative (if applicable) Relationship to patient (if applicable)

______________________ ______________

DH Representative Signature Date

Patient Consent to Treatment

IMPORTANT: DO NOT SIGN THIS FORM WITHOUT READING AND UNDERSTANDING ITS CONTENTS.

In consideration of services provided by Reveal Diagnostic Imaging of Pennsylvania, LLC (RDIP), the Patient or undersigned representative acting on behalf of the Patient agrees and consents to the following.

1) CONSENT TO ROUTINE MEDICAL TREATMENT/SERVICES

Patient acknowledges he/she is voluntarily seeking Medical Treatment/Services from RDIP. Patient hereby consents to the rendering of Medical Treatment/Services as considered necessary and appropriate by his/her physician or other practitioner. Patient gives permission to the medical staff of RDIP to provide Medical Treatment/Services ordered or requested by his/her physician or other practitioner and those acting in his or her place. Medical Treatment/Services may be performed by "Healthcare Professionals" (physicians, nurses, technologists, technicians, physician assistants or other healthcare professionals). **The consent to receive "Medical Treatment/Services" includes, but is not limited to: examinations (x-ray or otherwise); laboratory procedures; medications; infusions; transfusions of blood and blood products; drugs; supplies; radiation therapy; recording/filing for internal purposes (i.e., identification, diagnosis, treatment, performance improvement, education, safety, security) and other services which Patient may receive.**

2) LEGAL RELATIONSHIP BETWEEN RDIP AND PROVIDER

Some of the healthcare professionals performing services at RDIP are independent contractors and are not RDIP agents or employees. Independent contractors are responsible for their own actions and RDIP shall not be liable for the acts or omissions of any such independent contractors.

3) EXPLANATION OF RISK AND TREATMENT ALTERNATIVES

Patient acknowledges that the practice of medicine is not an exact science and that **NO GUARANTEES OR ASSURANCES HAVE BEEN MADE TO THE PATIENT** concerning the outcome and/or result of any Medical Treatment/Services. While routinely performed without incident, there may be material risks associated with each of these Medical Treatment/Services. Patient understands that it is not possible to list every risk for every Medical Treatment/Service and that this form only attempts to identify the most common material risks and the alternatives (if any) associated with the Medical Treatment/Services. Patient also understands that various Healthcare Professionals may have differing opinions as to what constitutes material risks and alternative Medical Treatment/Services. ***By signing this form:*** Patient consents to Healthcare Professionals performing Medical Treatment/Services as they may deem reasonably necessary or desirable in the exercise of their professional judgment, **including those Medical Treatment/Services that may be unforeseen or not known to be needed at the time this consent is obtained;** and Patient acknowledges that Patient has been informed in general terms of the nature and purpose of the Medical Treatment/Services; the material risks of the Medical Treatment/Services and practical alternatives to the Medical Treatment/Services.

The Medical Treatment/Services may include, but are not limited to the following:

a) **Needle Sticks**, such as shots, injections, intravenous lines or intravenous injections (IVs). The material risks associated with these types of Procedures include, but are not limited to, nerve damage, infection, infiltration (which is fluid leakage surrounding tissue), disfiguring scar, loss

   of limb function, paralysis or partial paralysis or death. Alternatives to Needle Sticks (if available) include oral, rectal, nasal or topical medication (each of which may be less effective).

b) **Physical Tests, Assessments, and Treatments** such as vital signs, internal body examinations, wound cleaning, wound dressing, range of motion checks, and other similar procedures. The material risk associated with these Procedures include, by are not limited to, allergic reactions, infection, severe loss of blood, muscular-skeletal or internal injuries, nerve damages, loss of limb function, paralysis or partial paralysis, disfiguring scar, worsening of the condition, and death. Apart from using modified Procedures, no practical alternatives exist.

c) **Administration of Medications** via appropriate route whether orally, rectally, topically, or through Patient's eyes, ears, or nostrils, etc. The material risks associated with these types of Procedures include, but are not limited to, perforation, puncture, infection, allergic reaction, brain damage, or death. Apart from varying the method of administration, no practical alternatives exist.

d) **Drawing Blood, Bodily Fluids, or Tissue Samples** such as that done for laboratory testing and analysis. The material risks associated with this type of Procedure include, but are not limited to, paralysis or partial paralysis, nerve damage, infection, bleeding, and loss of limb function. Apart from long-term observation, no practical alternatives exist.

e) **Insertion of Internal Tubes** such as bladder catheterizations, nasogastric tubes, rectal rubes, drainage tubes, enemas, etc. The material risks associated with these types of Procedures include, but are not limited to, internal injuries, bleeding, injection, allergic reaction, loss of bladder control, and difficulty urinating after catheter removal. Apart from external collection devices, no practical alternatives exist.

f) **Radiological Studies** such as X-rays, CT scans, or MRI scans. The material risks associated with these types of Procedures include, but are not limited to, radiation exposure. No practical alternatives exist.

If Patient has any questions or concerns regarding these Medical Treatment/Services, Patient will ask Patient's provider to provide Patient with additional information.

4) NOTICE OF PRIVACY PRACTICES

Patient acknowledges that Patient has received a copy of RDIP's Notice of Privacy Practices.

5) PATIENT'S PERSONAL VALUABLES

Patient agrees to retain responsibility for Patient's personal belongings at all times while on RDIP's property. RDIP shall not be liable for the loss or damage of any personal belongings, including, but not limited to, money, cell phones, laptops, electronic devices, jewelry, hearing aids, computers, or dentures.

6) CONSENT TIMEFRAME AND APPLICABILITY

The above consents are valid for a period of one (1) year from the date of signature below.

Validity of Form

Patient acknowledges that a copy, or an electronic version of this document may be used in place of and is as valid as the original.

Patient understands that the Healthcare Professionals participating in the Patient's care will rely on Patient's documented medical history, as well as other information obtained from Patient, Patient's family, or others having knowledge about Patient, in determining whether to perform or recommend the Procedures; therefore, Patient agrees to provide accurate and complete information about Patient's medical history and conditions.

Patient confirms that Patient has read and understood and accepted the terms of this document and the undersigned is the Patient, the Patient's legal representative, or is duly authorized by the Patient as Patient's general agent to execute the above and accept its terms.

_______________________________ _______________________________
Patient/Patient Representative Signature | Patient Name **(PRINT)** | Date

_______________________________ _______________________________
Relationship to Patient | Reason Patient is unable to sign

_______________________________ _______________________________
RDIP Representative Signature | RDIP Representative Name **(PRINT)** | Date