Imaging Specialists

PATIENT INFORMATION	UPDATED INFORMATION
MRN#	
Name	
DOB	
Address	
City, State, Zip	
Social Security #	
Home Phone #	
Work/ Mobile Phone#	
Email Address	
Policy Holder	
Relationship	
Guarantor DOB	

SCHEDULED EXAM:

Ref. Physician _____

Ref. Physician Phone _____

Additional Physicians:

Physician / Phone # _____

I understand that I am responsible for my bill and any charges or charge balances not paid by my insurance. I understand that there will be a fee of $35.00 for any checks returned for insufficient funds. I authorize payment direct to my physician. I authorize use of all medical information to process this claim. I authorize the qualified medical personnel of this facility to perform this procedure.

_____ _____

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENATIVE DATE

Imaging Specialists

MEANINGFUL USE FORM

PATIENT NAME: **DOB:** **MRN:**

Meaningful Use Defined:

Meaningful use is using certified electronic health record (EHR) technology to:

- Improve quality, safety, efficiency, and reduce health disparities
- Engage patients and family
- Improve care coordination, and population and public health
- Maintain privacy and security of patient health information

Ultimately, it is hoped that the meaningful use compliance will result in:

- Better clinical outcomes
- Improved population health outcomes
- Increased transparency and efficiency
- Empowered individuals
- More robust research data on health systems

Meaningful use sets specific objectives that eligible professionals (EPs) and hospitals must achieve to qualify for Centers for Medicare & Medicaid Services (CMS) Incentive Programs.

Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino **Preferred Language:** _____

Please indicate any Family Health History -

Mother_____ **Father**_____

Sister_____ **Brother**_____

Race: (Please check one)

□ American Indian or Alaska Native □ Asian □ Black or African American □ Caucasian

□ Pacific Islander or Native Hawaiian □ Other

Smoking Status: (Please check one)

□ Current everyday □ Current some day smoker □ Former smoker □ Never smoker □ Unknown

Height: **Weight :** **Blood Pressure:** _____

Please list any known allergies (Include reaction):

_____

_____

Please list your current medications :

_____

_____

Imaging Specialists

PATIENT RIGHTS AND AUTHORIZATION

PATIENT NAME: **DOS:** **MRN:**

A. Patient Rights: Please check the appropriate box below:

☐ I have been informed of my patient rights.

☐ I have been offered a written copy of my patient rights

B. Authorization to Release Medical Information to Family Members/Friends:

I give permission to Imaging Specialists to release information regarding appointment dates/times and my protected health information, including but not limited to, insurance, address, phone number, healthcare information, and treatment to the following individuals:

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

PLEASE CHECK HERE IF YOU DO NOT WISH TO LIST ANYONE ☐

_____ _____

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENATIVE DATE

_____

PRINT NAME OF ABOVE SIGNATURE