

AUSTIN RADIOLOGICAL ASSOCIATION PATIENT INFORMATION FORM

MRN: Folder #: Scheduled Date: Document Name:

Accession #: _____ Org Code: _____ MRN#: _____ Scheduled for: _____

Patient Name: _____ Social Security Number: _____

Date of Birth: _____ Sex: _____ Pregnant? Yes ___ No ___ Unknown ___

Mailing Address: _____
Street/Apt# City/State Zip

Primary Phone: _____

Employer: _____ Work Phone: _____

Emergency Contact (name and phone): _____ Relationship: _____

Do you currently reside in a Skilled Nursing Facility / Assisted Living Residence? Yes ___ No ___

If Yes, Facility Name: _____

Exam: _____

Patient Symptoms: _____

Date of Onset of Illness: _____

Patient Allergies: _____

Requesting MD: _____ Next visit with Requesting MD: _____

(Date/Time)

Send Additional Reports to: _____

Is this due to an accident / injury? Yes ___ No ___ Auto: ___ Work Related: ___ Date: _____

(If work related, please complete the Worker's Compensation section on next page.)

INSURANCE INFORMATION: (Please complete all information below. If not applicable, please insert "N/A")

PRIMARY MEDICAL

SECONDARY MEDICAL

(If Medicare, fill in section below and see Medicare box on page 2)

Insurance Company: _____ Insurance Company: _____

Insurance Co. Address (Line1): _____ Insurance Co. Address (Line1): _____

Insurance Co. Address (Line2): _____ Insurance Co. Address (Line2): _____

Insurance Co. Phone: _____ Insurance Co. Phone: _____

Policy # _____ Group # _____ Policy # _____ Group # _____

Name of Insured (Policy Holder): _____ Name of Insured (Policy Holder): _____

Insured's Address: _____ Insured's Address: _____

Insured's Phone: (Home) _____ (Work) _____ Insured's Phone: (Home) _____ (Work) _____

Insured's Date Of Birth: _____ Insured's Date Of Birth: _____

Insured's Social Security #: _____ Insured's Social Security #: _____

Insured's Employer: _____ Insured's Employer: _____

Relationship To Patient: _____ RelationshipTo Patient: _____

Please provide name and address of Guarantor (responsible party) for patient balance for services rendered.

Same as patient

Name: _____

Mailing Address: _____
Street/Apt# City/State Zip

Phone: _____ SSN: _____

Continued on Next Page...

Patient Name: _____ MRN#: _____ Accession #: _____

If Medicare or Railroad Medicare is your Secondary Insurance please indicate the reason below:

- | | |
|--|--|
| <input type="checkbox"/> 12 - You or your spouse are employed and are covered by you/their employers health insurance plan | <input type="checkbox"/> 41 - Black Lung |
| <input type="checkbox"/> 13 - End Stage Renal Disease (ESRD) | <input type="checkbox"/> 42 - Veteran's Administration (VA) |
| <input type="checkbox"/> 14 - No fault accidents and Auto accidents | <input type="checkbox"/> 43 - Patients under the age of 64 that are eligible for disability and covered by a large group health plan |
| <input type="checkbox"/> 15 - Worker's Compensation | <input type="checkbox"/> 47 - Any Liability Insurance |
| <input type="checkbox"/> 16 - Public Health Service (PHS) or other Federal Agency | |

This section to be completed for Worker's Compensation Claims Only

Employer (At time of Injury): _____ Date of Injury: _____

Employer Contact Person & Phone # _____

Briefly Describe the Original Cause of Injury: _____

Name of Workers Compensation Insurance Company: _____

Mailing Address: _____

Street

City/State

Zip

Claim # _____ Claim Adjuster Name: _____ Phone: _____

Have you previously had this procedure for this injury performed? Yes ___ No ___

I understand that businesses in the state of Texas have the option of providing Worker's Compensation insurance or an accident policy. By Law, Worker's Compensation insurance requires ARA to file your claim. It is not required by law that the provider of service file this claim if your employer has an accident policy. However, we do provide this service as a courtesy to our patients. Patients filing under an accident policy may be responsible for payment.

Signature

Date

PRIVACY NOTICE: I acknowledge I have been given the opportunity to read and receive a copy of the ARA Notice of Privacy Practices that explains to me how ARA will use and disclose my information. I understand that ARA does not need my permission to disclose health information for purposes related to treatment, payment, or routine business operations.

MEDICAL RELEASE/ASSIGNMENT OF BENEFITS: I hereby authorize payment of all health insurance benefits to Austin Radiological Association and allow assignee to release all information necessary to secure payment. I agree that a photocopy of this authorization shall be considered as effective and valid as the original. **I understand that I am legally responsible for all charges incurred whether or not they are paid by my health insurance, and that any unpaid balance shall be due in full IMMEDIATELY if insurance proceeds are paid directly to me.** I hereby authorize release of my medical records, inclusive of all test results and pertinent information acquired during my treatment, to/from other physicians as deemed necessary.

HIV TESTING AFTER ACCIDENTAL EXPOSURE: I understand that in the event a healthcare worker is exposed to my blood or body fluids during my exam/procedure, my blood may be tested for HIV antibody and other communicable disease at no cost to me.

TREATMENT CONSENT: I am consenting to any procedures performed on this date and these procedures have been explained to me.

SIGNATURE: _____ DATE: _____
(Patient / Parent / Legal Gaurdian)

PRINTED NAME: _____ TELEPHONE NUMBER: _____

ADDRESS (if different from patient address):

Street

City / State

Zip