ARA Diagnostic Imaging
PATIENT INFORMATION FORM

Exam Date: _____ Org Code: _____ Accession # _____ MRN# _____

Patient Name: _____ Social Security Number: _____

Date of Birth: _____ Age: _____ Email: _____

Would you like to be notified about other ARA services and health screenings? Yes ☐ No ☐

Mailing Address: _____
Street Apt# City/State Zip

Primary Phone: _____ Mobile Phone: _____ ☐ Permission to text

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

GUARANTOR NAME: _____ ☐ Same as Patient
(Responsible party for patient balance)

Mailing Address: _____
Street Apt# City/State Zip

SSN: _____ Primary Phone: _____

Requesting MD: _____ Address: _____

Results to 2nd MD: _____ Patient Symptoms: _____

CONSENT TO CONTACT: I acknowledge and agree that ARA can contact me for any purpose related to services I will receive at ARA including appointment reminders through any of the methods listed above. I agree to communicate any changes to my contact information immediately. I am aware standard text messaging fees may apply and text messages and emails are not sent through a secured encryption process so there is risk my information could be read by someone else.

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.

RELEASE OF MEDICAL RECORDS: By signing this form, I hereby authorize release of my medical records, inclusive of all test results and pertinent information acquired during my treatment, to/from other physicians and healthcare providers. This authorization extends to all of my protected health information maintained by ARA and is valid until revoked. The information that may be disclosed includes but is not limited to: statements of charges or payments, records of all visits, and records provided to or received by other physicians and providers. I understand that I may revoke this authorization at any time, except where information has already been released. The revocation must be in writing and sent to Attention: Privacy Officer, Austin Radiological Association, P.O. Box 4099, Austin, TX 78765. In addition, I understand that I have the right to request a copy of my medical record, or a portion thereof, at any time, and that ARA will do its best to timely respond to my request. I acknowledge and understand that I may incur fees associated with the copying of such medical records. ARA, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. I further understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and is no longer protected.

☐ By signing below, I hereby authorize the release and disclosure of my medical information to the following individuals (e.g. family/friends)

☐ Check here if you want only records related to today's date of service to be released to the individual(s) named below.

_____ (Name) _____ (Relationship) _____ (Name) _____ (Relationship)

ASSIGNMENT OF BENEFITS: I hereby authorize payment of all health insurance benefits to ARA and allow ARA 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. As the Patient or Guarantor, 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 shall promptly remit payment to ARA.

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 the provision of any medically-necessary tests or procedures to be performed on this date. I affirm that I have not taken any medications or substances that might affect my judgment or understanding of this document.

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

PRINTED NAME: _____