PATIENT HISTORY QUESTIONNAIRE

PATIENT'S NAME: _____

DOB: _____ **AGE:** _____ **HEIGHT:** _____ **WEIGHT:** _____

SIGNATURE: _____ **DATE:** _____

Describe your symptoms or the reason for this study in detail. _____

_____

_____

_____

Insurance requires a specific date relating to this procedure in month day year format, please complete accordingly

Injury date___/___/_____ Follow up to surgery – list surgical date ___/___/_____ Follow up to known tumor ___/___/_____

If this is chronic pain, how long have you had your pain? _____ Specify the date of increase pain or new symptoms ___/___/_____

List ANY previous surgeries:

_____

_____

_____

_____

List all medications you are currently taking:

_____

_____

_____

Please answer the following questions pertain to your personal history:

- ❑ Do you have any pacemakers, stents, artificial heart valves, aneurysm clips, IUD, hearing aids and/or any medical implants? No Yes
- ❑ **If you answered yes to the above question**, please note the item _____
- ❑ Are you wearing any transdermal patches (nitro/nicotine, birth control, etc)? No Yes
- ❑ Do you work with metal or has any metal been removed from your eyes? No Yes If yes, notify staff.
- ❑ Have you ever been wounded by a gun shot? No Yes If yes, was the bullet removed? No Yes
- ❑ Have you ever had a reaction to the MRI contrast? No Yes N/A
- ❑ Do you have a personal history of kidney problems? No Yes
- ❑ Do you have a personal history of diabetes? No Yes
- ❑ Do you have a personal history of high blood pressure? No Yes
- ❑ Do you have a personal history of asthma? No Yes
- ❑ Do you have a personal history of Sickle Cell disease? No Yes If yes, is it only the trait? No Yes
- ❑ Are you pregnant or breast feeding? No Yes N/A
- ❑ Do you have a personal history of cancer? No Yes If yes, what type? _____
- ❑ Are your symptoms injury related? No Yes If yes, how did the injury occur and what date? _____
- ❑ Have you had any previous diagnostic studies (i.e. X-ray; ultrasound; MRI; CT etc) of the same area we are scanning? No Yes If yes, what and where? _____

CAPITAL IMAGING, LLC

PATIENT INFORMATION:

Patient Last Name: _____ First: _____ MI: _____
Address: _____ Apt: _____
City: _____ State: _____ Zip: _____
Phone: Home _____ Work _____
Sex: M / F Date of Birth (M/D/Yr): _____ Age: _____
Marital status: (S)(M)(D)(W) Social Security #: _____
Employer Name: _____
Emergency Contact: _____ Phone: _____

IF PATIENT IS A MINOR:

Parent/Guardian Name: _____ Relationship: _____
Address, if different: _____ Phone: _____
City: _____ State: _____ Zip: _____

WORK COMP INJURY? _____ AUTO ACCIDENT INJURY? _____

PATIENTS MEDICAL INSURANCE (Please provide card)

Name of Insurance Company: _____
Subscriber Name: _____ Relationship to Pt.: _____
Subscriber's Social Security #: _____ Subscriber DOB: _____
Employers Name (Group): _____
ID #: _____ Group #: _____
Secondary Insurance Company: _____
Subscriber's Name: _____ Relationship to Pt: _____
SS#: _____ DOB: _____ ID# _____ Group # _____

I hereby authorize ***Capital Imaging, LLC*** to apply for benefits on my behalf for covered services rendered. I request payments from Blue Shield/Carefirst, Medicare and/or _____(name of insurance company) be made directly to the above provider.

I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim, to the above named billing agent (or in case of Medicare part B benefits, to the Social Security Administration and Health Care Financing Administration) and/or the insurance company named above. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or the above named carrier at any time in writing.

I request the payment of authorized Medigap benefits be made either to me or on my behalf to the above named provider for any services furnished me by this physician/supplier. I authorize any holder of medical information about me to release to Capital Imaging, LLC any information needed to determine those benefits payable for related services.

I understand that in the event that my insurance denies the claim or I fail to obtain all of the necessary information, I will be fully responsible for all payments. If it is necessary to turn this account over to a collection agency/attorney, I agree to pay all reasonable costs of collections, attorney fees and a one time service charge of 25% of the balance due.

_____ _____ _____
Patient Signature Date Office Staff Witness

Capital Imaging

4927 Auburn Avenue, Suite T-25
Bethesda, Maryland 20814
Phone (301)718-3411 Fax (301) 718-0805

Date: _____

Patient Name: _____

Films and/or a CD will be released to you after your procedure.

Your follow up appointment with your physician is scheduled:

____ Date: _____ ____Have not scheduled appointment

Please email me a copy of my report to the following email address:

_____

I understand that when my email is released that my email address may or may not have the appropriate security to be considered HIPAA compliant but I still choose to have my report email. Be advised your email will not be sent prior to three business days.

If you wish to have your reports mailed, please notify the staff and we will give you an envelope to self address.

Please send the radiology report to the following additional physicians:

Name	Fax Number
_____	_____
_____	_____
_____	_____
_____	_____

I understand that if **additional** copies of films/CDs are requested there will be an additional charge. Studies generated on a CD will cost $25.00. If films are printed, the charge will be $15.00 per sheet. The payment will be collected prior to printing/burning the images.

Signature of patient: _____

Note: If your doctor doesn't need your films for surgery or further evaluation, make sure you keep your films for future comparisons.

CAPITAL IMAGING
4927 Auburn Avenue Suite T-25 Bethesda, MD 20814
Phone 301-718-3411
Fax 301-718-0805

NOTICE OF PRIVACY PRACTICES

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. You have the right to obtain a paper copy of this Notice upon request.

Patient Health Information

Under federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also includes payment, billing, and insurance information.

How We Use Your Patient Health Information

We use health information about you for treatment, to obtain payment, and for health care operations, including administrative purposes and evaluation of the quality of care that you receive. Under some circumstances, we may be required to use or disclose the information even without your permission.

Example of Treatment, Payment, and Health Care Operations

Treatment: We will use and disclose your health information to provide you with medical treatment or services. For example, nurses, physicians, and other members of your treatment team will record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, and to family members who are helping with your care.

Payment: We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payments from your health plan.

Health Care Operations: We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment, and to assess the care and outcomes of your case and others like it.

Special Uses

We may use your information to contact you with appointment reminders. We may also contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Other Uses and Disclosures

We may use or disclose identifiable health information about you for other reasons, even without your consent. Subject to certain requirements, we are permitted to give out health information without your permission for the following purposes:

Required by Law: We may be required by law to report gunshot wounds, suspected abuse or neglect, or similar injuries and events.

Research: We may use or disclose information for approved medical research.

Public Health Activities: As required by law, we may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.

Health oversight: We may be required to disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.

Judicial and administrative proceedings: We may disclose information in response to an appropriate subpoena or court order.

Law enforcement purposes: Subject to certain restrictions, we may disclose information required by law-enforcement officials.

Deaths: We may report information regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies.

Serious threat to health or safety: We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Military and Special Government Functions: If you are a member of the armed forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes.

Workers Compensation: We may release information about you for workers compensation or similar programs providing benefits for work-related injuries or illness.

In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

Individual Rights

Your have the following rights with regard to your health information. Please contact the person listed below to obtain the appropriate form for exercising these rights.

Request Restrictions: You may request restrictions on certain uses and disclosures of your health information. We are not required to agree to such restrictions, but, if we do agree, we must abide by those restrictions.

Confidential Communications: You may ask us to communicate with you confidentially by, for example, sending notices to a special address or not using postcards to remind you of appointments.

Inspect and Obtain Copies: In most cases, you have the right to look at or get a copy of your health information. There may be a small charge for the copies.

Amend Information: If you believe that information in your record is incorrect, or, if important information is missing, you have the right to request that we correct the existing information or add the missing information.

Accounting of Disclosures: You may request a list of instances where we have disclosed health information about you for reasons other than treatment, payment, or health care operations.

Our Legal Duty

We are required by law to protect and maintain the privacy of your health information, to provide this Notice about our legal duties and privacy practices regarding protected health information, and to abide by the terms of the Notice currently in effect.

Changes in Privacy Practices

We may change our policies at any time. Before we make a significant change in our policies, we will change our Notice and post the new Notice in the waiting area and each examination room. You can also request a copy of our Notice at any time. For more information about our privacy practices, contact the person listed below.

Complaints

If you are concerned that we have violated your privacy rights, or, if you disagree with a decision we made about your records, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.

Contact Person

If you have any questions, requests, or complaints, please contact:

ANDREW KOMISKE
4927 Auburn Avenue Suite T25
Bethesda, MD 20814
301.718.3411

I,_____
hereby acknowledge receipt of the Notice of Privacy Practices given to me.

Signed:_____Date: _____

If not signed, reason why acknowledgement was not obtained: _____

Staff Witness seeking acknowledgement:

Signed:_____Date: _____