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PATIENT REGISTRATION AND CONSENT FOR TREATMENT

CONSENT FOR TREATMENT. I voluntarily consent to all medical and surgical treatment performed by my physician and all other health care providers at ImageMed health care delivery sites. I also consent to routine services, diagnostic procedures, medical treatment, other health care services deemed necessary by the health care providers treating me. I understand that the practice of medicine and surgery is not an exact science and that diagnosis and treatment may cause injury or even death. I understand that I have a right to consent or to refuse to consent to any proposed surgery, procedure or treatment, and to discuss it with my health care provider. I also understand that in the course of my medical treatment I may have one or more photographs, video tapes or records of my skin or wound(s) taken, to use in monitoring my treatment and guiding healthcare provider interventions. I hereby release ImageMed and any of its Employees, Physicians, or Contractors from any responsibility or liability which might arise from the taking or use of authorized negatives, prints, slides, video or any digital file. I understand that if an employee or any individual associated with ImageMed is exposed to my blood or bodily fluids, I will be tested for hepatitis viruses and the Human Immunodeficiency Virus (HIV).

AUTHORIZATION, FOR RELEASE OF INFORMATION. I authorize ImageMed, its affiliates and its health care delivery sites to utilize confidential medical/Surgical or other information contained in my medical record as necessary for claims payment, medical management, or quality of care review purposes. I further authorize the release and discharge of such confidential, information to my insurance company or other health coverage plan, including government payers, as necessary for claims payment, medical management and quality review activities conducted by such company or plan, or its designees. This authorization includes the release of an Acquired Immunodeficiency Syndrome (AIDS) diagnosis or a positive Human Immunodeficiency Virus (HIV) antibody test result, alcohol and/or drug abuse information, genetic testing, congenital disorders, and mental health information. I understand this authorization for release of information can be revoked by me in writing at any time, but only with respect to the proposed treatment and not with respect to care and treatment that has already been rendered to me.

WAIVER OF RESPONSIBILITY FOR PERSONAL VALUABLES. I understand that ImageMed, its affiliates or any of its health care delivery sites do not assume any responsibility for the loss or damage to my personal property.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES. I acknowledge that I have received or been offered a copy of Physician Office's Notice of Privacy Practices which provides information on how ImageMed may use or disclose PHI for purposes of treatment, payment, or health care operations.

PAYMENT AGREEMENT AND ASSIGNMENT. Except as prohibited by any agreement between my insurance company and ImageMed, its affiliates or by state or federal law, I agree to be responsible for my co---payments, deductibles or other charges for medical services not covered or paid by insurance or other third party payers. I authorize ImageMed or its affiliates to file any claims for

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payment of any portion of the patient bills and assign all rights and benefits to ImageMed or its affiliates as appropriate. I further agree, subject to state or federal law, to pay all costs, attorney fees, expenses and interest in the event ImageMed or its affiliates take action to collect same because of my failure to pay in full all incurred charges.

I have read this form, and by signing this form I understand and agree to what it says.
The consent for treatment shall be effective for (1) year

_____	_____
Patient Signature (Or parent/guardian/other authorized person if Patient is a minor, mentally incompetent, or physically unable to sign this form)	**Date**
	_____
	Witness to signature
_____	_____
Printed name and relationship of person Authorized to sign for Patient	**Reason Patient is unable to sign**

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New Patient Intake Form

Date: _____

I. Demographic Information

Name:_____ Date of Birth:_____ Age:_____ MR #:_____

Home Address: _____

Home phone:_____ Cell Phone: _____

Email:_____

Do you give us permission to leave Voice Messages containing personal health information on the phone numbers listed above? Yes r No r

Emergency Contact Name & Number: _____

II. Care Information

Please list complete name of physicians **(VERY IMPORTANT)**

Primary Care Physician: _____

Address: City:_____ State:_____ Zip:_____

Phone: Fax:_____ Email:_____ Referring Physician (if different from PCP):_____

_____ Specialty:_____ Other Physicians_____

_____ Specialty:_____ Other Physicians_____

_____ Specialty:_____ Other Physicians_____

_____ Specialty:_____ Other Physicians_____

_____ Specialty:_____ Other Physicians_____

_____ Specialty:_____ Pharmacy: _____

_____

Address: City:_____ State:_____ Zip:_____

Phone: Fax:_____

III. Reason For Visit

Please describe the major problem that brings you in today:

_____

_____

_____

_____

_____

_____

Please complete all pages.

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IV. Surgical History

Please list all operations you have had:

_____ Date: _____
_____ Date: _____
_____ Date: _____
_____ Date: _____
_____ Date: _____

V. Medical History

Please list all active medical conditions:

_____ Duration: _____
_____ Duration: _____
_____ Duration: _____
_____ Duration: _____
_____ Duration: _____

Please list all MEDICATIONS (including current and previous chemotherapy) you take routinely:

Name of Medication	Dosage	Frequency of Use

Are you **ALLERGIC** to any medicines, latex, X-ray dye or iodine? Yes r No r

If yes, please list allergies: _____

_____

_____

FEMALES: (Please fill in OR mark yes or no)

	Yes	No
Are you, or could you be pregnant?	r	r
How many times have you been pregnant? _____ How many children do you have? _____		
Are you still having menstrual periods?	r	r
How many days do they last? _____		
If you have heavy bleeding, what is the most number of pads per day? _____ For how many days? _____		
Do you have any constipation?	r	r
Ever used birth control pills?	r	r
Do you have any urinary urgency or frequency?	r	r
Have you had a recent Pap smear or Endometrial biopsy?	r	r
Do you have varicose veins?	r	r
Do you have pelvic pain?	r	r

VI. Social History

Occupation: _____ Marital Status: _____ Number of children: _____

Hobbies: _____

Do you smoke cigarettes? _____ If so, how many packs a day? _____

At what age did you start? _____ If applicable, at what age did you stop? _____

Do you drink alcohol? _____ If yes, how much daily? _____

At what age did you start? _____ If applicable, at what age did you stop? _____

Do you use recreational drugs? _____ Type? _____

Please complete all pages.

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VII. Review of Systems

Please answer yes or no if you have any of the following:

	Yes	No
Constitutional:		
Fever	r	r
Weight loss	r	r
Excessive fatigue	r	r
History of Falls	r	r
Eyes:		
Wear glasses	r	r
Infections	r	r
Injuries	r	r
Glaucoma	r	r
Cataracts	r	r
Ears, Nose, Throat & Mouth:		
Wear hearing aid(s)	r	r
Hearing loss	r	r
Ear pain/infections	r	r
Ringing in ears	r	r
Nose bleeds	r	r
Nasal congestion/drainage	r	r
Inability to smell	r	r
Sinus problems	r	r
Balance (vertigo, spinning, etc.)	r	r
Cardiovascular:		
Chest pain or angina	r	r
High blood pressure	r	r
Irregular pulse	r	r
Heart murmur	r	r
High cholesterol	r	r
Swelling in hands or feet	r	r
Leg pain while walking	r	r
Respiratory:		
Asthma	r	r
Emphysema	r	r
Shortness of breath	r	r
Pneumonia	r	r
Bloody sputum	r	r
Gastrointestinal:		
Nausea	r	r
Vomiting	r	r
Blood in your vomit	r	r
Liver disease	r	r
Jaundice	r	r
Abdominal pain	r	r
Change in bowel habits	r	r
Ulcers or gastritis	r	r

	Yes	No
Endocrine:		
Diabetes	r	r
Thyroid disease	r	r
Excessive thirst/urination	r	r
Genitourinary:		
Urinary tract infections	r	r
Painful urination	r	r
Blood in your urine	r	r
Difficult starting/stopping stream	r	r
Incontinence	r	r
Kidney stones	r	r
Musculoskeletal:		
Broken bones	r	r
Arm or leg weakness	r	r
Arm or leg pain	r	r
Joint pain or swelling	r	r
Arthritis	r	r
Integumentary:		
Skin disease	r	r
Breast pain, tenderness, nipple discharge	r	r
Neurological:		
Fainting spells or “black outs”	r	r
Seizures	r	r
Problems with memory	r	r
Disorientation	r	r
Difficulty with speech	r	r
Inability to concentrate	r	r
Double or blurred vision	r	r
Weakness in arms and/or legs	r	r
Loss of sensation	r	r
Difficulty with balance	r	r
Psychiatric:		
Anxiety	r	r
Depression	r	r
Hematologic/Lymphatic:		
Anemia	r	r
Hemophilia	r	r
Bleeding tendencies	r	r
Blood transfusion	r	r
Persistent swollen glands/lymph nodes	r	r
HIV	r	r
Allergic/Immunologic:		
Food, Inhalant (nasal) allergies	r	r
Autoimmune disease (i.e., lupus)	r	r

VIII. Nutrition Assessment

	Yes	No
Have you experienced daily vomiting/diarrhea for more than two days?	r	r
If yes, please explain: _____		
Have you experienced nausea or poor appetite for more than five days?	r	r
If yes, please explain: _____		
Have you lost weight without wanting to?	r	r
If so, how many pounds? _____		

Please complete all pages.

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IX. Energy level

	Yes	No
Are you able to do physically strenuous activities?	☐	☐
Do you have enough energy to do all the things that you want?	☐	☐
How many hours do you sleep at night? _____		
Do you take naps during the day?	☐	☐
Is this more than 1/2 the time you are awake?	☐	☐

X. Do you have a Health Care Medical Power of Attorney? ☐ ☐

If yes, please list: _____

_____

XI. Any other information that we need to know?

_____

_____

_____

_____

_____

_____

The information on this form is accurate to the best of my knowledge:

_____ _____

Patient's Signature Date

_____

Printed Name

Please complete all pages.

Financial Policy

PURPOSE

ImageMed is dedicated to providing you with the best possible care and service available, and we feel an understanding of our financial policies is an essential element of your care and treatment.

AUTHORIZATION TO RELEASE INFORMATION

I authorize the release of any medical records or other information needed to process my health claim.

YOUR INSURANCE

As a courtesy, ImageMed verifies your benefits with your insurance company. A quote of benefits is not a guarantee of benefits or payment.

ImageMed will bill your insurance company. Our services may or may not be covered by your insurance plan. If any services you receive are covered by your insurance plan you will be responsible for co-pays, deductible amounts and/or co-insurance (collectively known as Patient Responsibility) at the time of service. If any services you receive are not covered by your insurance plan, you will be responsible for the total charges for non-covered services (non-covered charges). Estimated payment for your Patient Responsibility, as well as payment for non-covered charges, are required at the time of service. This payment will be collected when you arrive for your visit. Patient Responsibility collections will pay down your co-pay, deductible and/or co-insurance obligations.

You are responsible for all charges incurred; your physician's referral and our verification of your insurance benefits are not a guarantee of payment. We recommend you also contact your insurance carrier and check into your coverage. Do not assume that you will owe nothing if you have more than one insurance policy. Being referred to our clinic by another physician does not guarantee that your insurance plan will cover our services.

CREDIT CARD POLICY

At ImageMed we keep your credit or debit card on file as a convenient method of payment for the portion of your bill that your insurance plan identifies as your patient responsibility plus any non-covered charges. Your credit card information is kept secure by a 3rd party PCI compliant merchant gateway. Our estimate of your patient responsibility and any non-covered charges will be charged at the time of service. Once the insurance company processes the claim, the final Patient Responsibility will be declared to you and to ImageMed in the form of an Evidence of Benefits, usually mailed to your home and sent to ImageMed electronically. It is ultimately the insurance company that determines the Patient Responsibility for covered services. ImageMed will only collect the amount that your insurance company identifies as your Patient Responsibility PLUS our charges for any non-covered services. Our contracts with the insurance companies require that we collect the full Patient Responsibility for covered services. To this end, if ImageMed underestimated the Patient Responsibility at the time of service, additional charges for outstanding balances will be posted to your credit card immediately upon receipt of the Evidence of Benefits. If ImageMed overestimated your Patient Responsibility, any overcharge by us will be refunded to you promptly.

Financial Policy

BILLING FEE

When we receive the Evidence of Benefits for your encounter we will attempt to reconcile your account by charging any outstanding balance to your credit card, or by refunding any credit balance to your credit card. In the case of an outstanding balance ImageMed will add a $25 billing fee to your account if both of the following apply: 1) ImageMed has no credit card saved to your account, or your credit card is expired or declined; and 2) your account remains unpaid after our first attempt to collect any outstanding balance from you, whether by phone or mailed statement or both. There will be no billing fees if ImageMed is able to collect your outstanding balance on the first attempt.

For questions about this policy or for billing issues, please call our front desk at (480) 907-7572.

_____ (Initial Here)

I understand and accept the terms of ImageMed's financial policy. I understand that ImageMed will only collect from me my Patient Responsibility, as determined and directed by my insurance company, plus charges for services not covered by my insurance company.

Patient Name: _____

Patient Signature: _____

Cardholder Name (if different) _____

Billing Address (if different from patient's address): _____

Date: _____/_____/_____

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Authorization to release/
Obtain protected health information

Patient Name:_____ Date of Birth: _____

I hereby authorize ImageMed to disclose my entire medical record including information regarding my billing, condition, treatment and diagnosis to the following individual(s):

Name:_____ Relationship: _____

Name:_____ Relationship: _____

I hereby authorize:

Facility/Entity:_____ Address: _____

Facility/Entity:_____ Address: _____

To release protected health information, this may include: films, reports and laboratory results to ImageMed.

_____ _____

Patient Signature Date

Please complete all pages.

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Email Policy

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) required the Secretary of the U.S. Department of Health and Human Services (HHS) to develop regulations protecting the privacy and security of certain health information. To fulfill this requirement, HHS published what are commonly known as the HIPAA Privacy Rule and the HIPAA Security Rule.

The Privacy Rule, or Standards for Privacy of Individually Identifiable Health Information, established national standards for the protection of certain health information. The Security Rule, or Security Standards for the Protection of Electronic Protected Health Information, established a national set of security standards for protecting certain health information that is held or transferred in electronic form.

The Security Rule does not expressly prohibit the use of email for sending electronic protected health information (PHI). However, the standards for access control (45 CFR § 164.312A)), integrity (45 CFR § 64.312(c)(1)), and transmission security (45 CFR § 164.312(e)(1)) require covered entities to implement policies and procedures to restrict access to electronic PHI sent and received over e-mail communications.

ImageMed uses an e-mail provider that has demonstrated compliance with security standards in the industry, and the staff of ImageMed vigorously exercise appropriate precautions to protect your PHI. However, we are unable to guarantee the security of your information via e-mail communication, in particular because we cannot verify that your internet provider or your points of access are similarly secure. It is our policy to engage in e-mail communications that contain PHI if and only if you expressly understand and acknowledge these limitations and risks.

I,_____, acknowledge receipt and understanding of the above information.
(Patient Name)

Please initial one of the following to indicate your preference:

_____ (initial if yes) Yes, I understand the foregoing and approve of engaging in e-mail communication with ImageMed, which may include private health information. I may revoke this decision in writing at any time.

_____ (initial if no) No, I do not wish to engage in e-mail communication with ImageMed.

_____
Date

Please complete all pages.

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General Media Release

I,_____(patient name), authorize ImageMed to obtain and archive xray, ultrasound, and photographic images for medical purposes, to be used for my patient care, marketing, literature and/or case presentations.

I understand that:

- Images are taken to document diagnostic and treatment procedures.
- Images may be used for print, visual or electronic media, including but not limited to scientific presentations, our website, and for purposes of informing the medical profession or general public about the procedure. These uses may also include marketing on behalf of ImageMed.
- The images taken of me may be published by ImageMed.
- I will not be identified by name in any of the published materials.
- Published images will never reveal my face, nor will they ever include identifying features or information.
- Images are archived in a HIPAA-compliant secure third-party server.
- I have the right to revoke this authorization in writing at any time through a written revocation to ImageMed.

I hereby release ImageMed and its agents from any and all claims and demands arising out of, or in conjunction with, the use of the images.

_____ (initial) By initialing, I certify that I have read this release carefully and fully understand its terms. If I have any questions, I can contact ImageMed at 480-907-7572.

Print Name: _____

Date: _____

Please complete all pages.