VALLEY IMAGING CONSULTANTS, LLC.

REGISTRATION FORM

(Please Print)

Today's date:	

PATIENT INFORMATION

Patient's last name: First: Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age: Sex: ❑ M ❑ F
Street address:	Social Security no.:	Primary Phone Number: ( )		
City:	State:	Zip Code:	Secondary Phone Number: ( )	
Occupation:	Employer Name:	Employer phone no.: ( )		
Referred to clinic by (please check one box): ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital ❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other				
Other family members seen here:				

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )		
Is this person a patient here? ❑ Yes ❑ No					
Occupation:	Employer:	Employer address:	Employer phone no.: ( )		
Is this patient covered by insurance? ❑ Yes ❑ No					
Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other					

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Valley Imaging Consultants or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature *Date*

VALLEY IMAGING CONSULTANTS, LLC.

Patient Name: _____ Date of Birth: _____

Email: _____
If Email is provided, it may be used for scheduling, confirming appointments, billing and/or other administrative purposes.

Preferred Communication: _____ PHONE _____ Email

_____ TEXT _____ Written Notification

PRIMARY CARE PHYSICIAN: _____

REFERRING PHYSICIAN: _____

PHARMACY NAME/LOCATION/Phone Number: _____

Preferred Language for Healthcare Communication: _____

In compliance with federal guidelines, we are required to record a patient's ethnicity, race, and preferred language.
Please complete the following (You may choose not to respond):

_____ DECLINE

Ethnicity: Are you of Hispanic, Latino, or Spanish Origin? _____ YES _____ NO

Race: *(please check all that apply)*

- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Other

The federal government considers Hispanic/Latino/Spanish to be an ethnicity, not a race. That is why Hispanic/Latino/Spanish is not listed as a race identification category.

VALLEY IMAGING CONSULTANTS, LLC.

NOTICE OF PRIVACY PRACTICES

(HIPAA)

Our Notice of Health Insurance Portability and Accountability Act provides information about how we may use and disclose protected health information about you. The notice contains a *"Patient's Rights"* section describing your rights under the law. You have the right to review our notice before signing this consent. You have the right to request that we restrict how protected health information about you is disclosed for your treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such a revocation will not affect any disclosures we have already made in reliance on your prior consent. Valley Imaging Consultants provides this information with the Health Insurance Portability and Accountability Act of 1996 (*HIPAA*)

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or healthcare operations
- Valley Imaging Consultants has a notice of privacy practices and the patient has the opportunity to review this
- Valley Imaging Consultants reserves the right to change the Notice of Privacy Policies
- Patients have the right to restrict the uses of their information but Valley Imaging Consultants does not have to agree to the restrictions
- Patients may revoke this consent in writing at any time and all future disclosures will then cease

Notice of Privacy Practices
I acknowledge that I have been offered a copy of the Notice of Privacy Practices.

Patient/Responsible Party Initials: _____
Date: _____

Disclosure of Information

I authorize Valley Imaging Consultants to leave detailed messages, which may include protected health information (e.g., test results):

Please check all that apply:

☐ On my home phone voice mail/answering machine. *Phone #:* _____
☐ On my cell phone voice mail. *Phone #:* _____
☐ On my work phone mail. *Phone #:* _____
☐ With a family member or caregiver identified below:

Name	Relationship	Phone #:
_____	_____	_____
_____	_____	_____

FINANCIAL POLICY

Our goal at Valley Imaging Consultants (VIC) is to provide you with the very highest level of care and also provide you with information that may be useful when making decision regarding insurance coverage and/or other financial matters relating to your health care. If you need further clarification or have any questions about the following information, please do not hesitate to ask.

1. I authorize VIC to submit claims on my behalf, and to release the necessary information to my insurance company for services rendered, I authorize my insurance company to direct payment of medical benefits to Valley Imaging Consultants or any of its physicians.
2. I understand that it is my responsibility to know the details of my health insurance plan including but not limited to pre-existing conditions, referrals, deductibles, coinsurance, benefit exclusions, and medical policy updates.
3. I understand that I am financially responsible for all remaining balances on my account including but not limited to deductibles, coinsurance, copayments, and non-covered services.
4. I understand that when a service is "authorized" and/or "covered" by my insurance plan, I may still be responsible for payment to VIC for deductibles, coinsurance, and copayments, as determined by my insurance health plan.
5. I understand that my insurance company may deny a medical claim based on specific guidelines or criteria established by my health plan. If I disagree with the reason for denial of medical benefits payment, I can submit a written appeal to my insurance company but I am sill financially responsible to VIC. I understand that I may be responsible for the payment of any outstanding balance on my account before additional services will be provided by VIC.
6. By signing this document, I assume full financial responsibility for all payments and outstanding balances as outlined above.

My signature below acknowledges that I accept all of the above policies and procedures.

Patient Name (Please Print)	Date of Birth
Patient Signature	Date

If the patient was unable to sign this document, the responsible party must complete the information below.

Responsible Party Name (Please Print)	Relationship to Patient
Responsible Party Signature	Date

VALLEY IMAGING CONSULTANTS, LLC.

HEALTH HISTORY

Patient Name: _____ Date of Birth: _____

Sex: M F Height: _____ Weight: _____

Reason for your visit: _____

Please check if you have had any of the following symptoms WITHIN THE PAST YEAR:

GENERAL	EYES/EARS/NOSE/THROAT	MUSCLES/JOINTS/BONES
☐ Dizziness ☐ Fainting ☐ Fatigue ☐ Fever ☐ Headaches ☐ Sweats ☐ Weight Loss	☐ Bleeding Gums ☐ Blurred Vision ☐ Difficulty Swallowing ☐ Double Vision ☐ Earache ☐ Ear Discharge ☐ Hoarseness ☐ Loss of Hearing ☐ Mouth Sores ☐ Nosebleeds ☐ Ringing in Ears ☐ Sinus Problems ☐ Swollen Glands in Neck ☐ Visual Flashes ☐ Visual Halos	☐ Back Pain ☐ Foot Pain ☐ Hip Pain ☐ Knee Pain ☐ Cold Extremities ☐ Joint Stiffness/Swelling ☐ WEEKNESS/NUMBNESS in _ Arms _ Back _ Feet _ Hands _ Hips _ Legs _ Neck _ Shoulders
CARDIOVASCULAR	GASTROINTESTINAL	NEUROLOGICAL
☐ Chest Pain ☐ High Blood Pressure ☐ Low Blood Pressure ☐ Rapid Heart Beat ☐ Leg Cramps ☐ Poor Circulation ☐ Swelling of Ankles ☐ Varicose Veins	☐ Abdominal Pain ☐ Poor Appetite ☐ Bloating ☐ Bowel Changes ☐ Gas ☐ Hemorrhoids ☐ Rectal Bleeding ☐ Excessive Hunger ☐ Excessive Thirst ☐ Vomiting ☐ Vomiting Blood ☐ Ulcer Disease	☐ Convulsions or Seizures ☐ Head injury ☐ Paralysis ☐ Stroke ☐ Tingling or Numbness ☐ Tremors
RESPRAITORY	SKIN	ENDOCRINE
☐ Chronic Cough ☐ Shortness of Breath ☐ Spitting up Blood ☐ Wheezing	☐ Bruise Easily ☐ Change in Hair or Nails ☐ Changes in Moles ☐ Eczema ☐ Hives ☐ Itching ☐ Rash ☐ Sores that won't heal	☐ Excessive Urination ☐ Hot or Cold Intolerance

Check if you have EVER had any of the following medical conditions:

☐ Aids	☐ Chicken Pox	☐ HIV Positive	☐ Polio
☐ Alcoholism	☐ Diabetes TYPE:	☐ Kidney Disease	☐ Prostate Problems
☐ Anemia	☐ Emphysema	☐ Kidney Stones	☐ Psychiatric Care
☐ Anorexia	☐ Epilepsy	☐ Leg Ulcers	☐ Rheumatic Fever
☐ Appendicitis	☐ Glaucoma	☐ Liver Disease	☐ Scarlet Fever
☐ Arthritis	☐ Goiter	☐ Measles	☐ Sickle Cell Anemia
☐ Asthma	☐ Gonorrhea	☐ Migraine Headaches	☐ Stomach Ulcers
☐ Bleeding Disorder	☐ Gout	☐ Miscarriage	☐ Stroke
☐ Blood Clot(s)	☐ Heart Attack	☐ Mitral Valve Prolapse	☐ Suicide Attempt
☐ Breast Lump	☐ Heart Disease	☐ Mononucleosis	☐ Thyroid Problems
☐ Bronchitis	☐ Hepatitis TYPE:	☐ Multiple Sclerosis	☐ Tonsillitis
☐ Bulimia	☐ Hernia	☐ Mumps	☐ Transfusion YEAR:
☐ Cancer ORIGIN: Year:	☐ Herpes	☐ Pacemaker	☐ Tuberculosis
☐ Cataracts	☐ High Blood Pressure	☐ Phlebitis	☐ Vaginal Infection
☐ Chemical Dependency	☐ High Cholesterol	☐ Pneumonia	☐ Venereal Disease

OTHER: _____

PAST SURGERIES:
(Include name of procedure, year it was performed, please note LEFT/RIGHT if applies)

_____

_____

_____

_____

FAMILY HISTORY:
(Mother, Father, Sister, Brother, Children)

Hypertension *DVT* *Clotting Disorder* *Vascular Disease* *Cancer*

Other Medical Problems: _____

List which family member and what medical diagnosis applies: _____

_____

Allergies: *(list type of allergy: medication, environmental, food also list symptoms)*

NONE _____

_____

_____

_____

Medications: *(list name, dose, frequency taken)*

_____

_____

_____

_____

_____

_____

Do you take Aspirin Daily? _____

*Do you take any blood thinners like Coumadin, Plavix, Xarelto?*_____

*Do you take antibiotics prior to a dental procedure?*_____

Social History:

Do you smoke?	Y	N	If yes: What age did you start smoking? _____
			Number of packs per day: _____
			Have you ever thought about quitting? _____
Did you ever smoke?	Y	N	If yes, year/age that you quit? _____
Do you drink alcohol?	Y	N	If yes, how many drinks? _____
			Per Month/Week/Day? _____
Do you use illicit drugs?	Y	N	Type/Frequency? _____

_____ _____

Patient Signature Date