ria ENDOVASCULAR
Radiology Imaging Associates P.C.

Patient Registration Form

Please print all information.
Please correct label if applicable.

Date _____ **MRN**_____

PATIENT NAME_____ DOB_____

Previous Name/ Alias _____ ☐Male ☐Female ☐Other_____

Mailing Address_____ Phone/Cell _____

City _____ State_____ ZIP_____

Email _____ Employer_____

Patient Status ☐is a minor ☐has a guardian ☐is married

If checked above, Guardian/Spouse Name _____ Phone #_____

Preferred Language: ☐English ☐Other (please specify):

Would you prefer to speak to your healthcare provider using a translator? ☐Yes ☐ No

PHARMACY: Please identify your preferred pharmacies

	Name	**Address/Cross Streets**	**Phone Number**	**Preferred**
Local:	_____	_____	_____	☐
Alternative:	_____	_____	_____	☐

Your Physicians: Please identify your physician who should receive information on your visit.

Primary Care Provider_____ Phone Number_____

Specialist Name_____Specialty_____ Phone Number _____

Specialist Name_____Specialty_____Phone Number _____

Insurance Information

Primary Insurance: _____ Policy#_____ Group# _____

Name of Policy Holder: _____ Relationship: ☐ Self ☐Spouse ☐Child ☐Other

Secondary Insurance: _____ Policy#_____ Group# _____

Name of Policy Holder: _____ Relationship: ☐ Self ☐Spouse ☐Child ☐Other

Accident Type: _____ Date of Injury:_____

Communication

Radiology Imaging Associates can send me reminders, directions and surveys via text message: ☐ Yes ☐ No

Radiology Imaging Associates can send my detailed medical information to my email and home address: ☐ Yes ☐ No

Radiology Imaging Associates can leave detailed medical information on my voicemail: ☐Yes ☐No

I authorize, Radiology Imaging Associates to discuss or release any of my medical information to the following people (i.e. spouse, partner, child, other family member, care taker, etc..) Please Identify who:_____

_____

No Show Policy If you show up 15 minutes or more past your scheduled appointment time, you are considered late and we may need to reschedule your appointment. If you can't make an appointment, please let us know. We reserve the right to apply a no-show fee of **$75**, where allowable by law for no-show appointments.

How did you hear about us? Check as many as applicable

☐Physician ☐Ad ☐Article ☐Friend ☐Google ☐Letter ☐Social Media ☐TV ☐RIA Website ☐Other_____

FINANCIAL AGREEMENT I the undersigned patient do 1) hereby consent to the performance of diagnostic procedures, 2) authorize pay directly to Radiology Imaging Associates, PC and/or its affiliates, 3) authorize Radiology Imaging Associates, PC and/or its affiliates, to disclose for purposes of reimbursement or quality assurance my medical/surgical records to my insurance company or corporation or to any government agency. I jointly and severally agree to pay for all service provided. I understand and agree charges not paid may be placed with an attorney or collection agency, and that reasonable attorney fees and/or open account interest charges assessed are my responsibility.

Radiology Imaging Associates, PC and/or it affiliates may use your information to contact you via telephone for appointment reminders or billing related inquiries, or to tell you about or recommend possible treatment options alternatives, and health-related benefits or services that may be of use to you.

_____

Patient / Patient Representative Signature & Date

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Consent for Medical Treatment

Patient Name_____ **DOB**_____ **MRN**_____

Please verify by initialing each section

_____ **CONSENT FOR HEALTH CARE SERVICES**. I authorize physicians(s), therapists(s), their assistants and/or designees to administer any treatment as may be necessary or advisable in my diagnosis and treatment at RIA/ISJ practices. This authorization includes, but is not limited to, medical services, diagnostic procedures, intravenous therapy, medications, injections, laboratory services, and other services or procedures, which my physician or provider considers necessary in person or telehealth. My health care providers will discuss with me the risks, benefits and alternatives to recommended treatments. I understand that health care services may be rendered by students, interns or residents under supervision. I understand that the RIA practice may release copies of my medical records to other physicians, practitioners and healthcare facilities for treatment and other purposes, as permitted by law. I acknowledge that no promises or guarantees have been made to me regarding treatment or services rendered in by the practice. I understand that failure to comply with scheduled appointment times will put me at risk for discontinuation of medical care.

_____ **FINANCIAL AGREEMENT.** I acknowledge that I personally have full financial responsibility for, and agree to pay, all charges of the practice and of physicians rendering services not otherwise paid by my health insurance or other payer. I acknowledge that estimated patient responsibility is due at the time of service and that any remaining charges are due and payable upon receipt of the bill. I acknowledge it may not be possible to state in advance which specific supplies and services will be part of my treatment. I agree to pay these current pre-determined rates for each supply and service I receive as part of my treatment. I understand the practice may request and use data from third parties such as credit reporting agencies to verify demographic data or evaluate financial options. I understand and agree charges not paid may be placed with an attorney or collection agency, and that reasonable attorney fees and/or open account interest charges assessed are my responsibility. I acknowledge and understand that any refund that I may be owed will first be applied to any outstanding balance, and the remainder will be forwarded to the address on file with the practice.

_____ **ASSIGNMENT OF BENEFITS.** I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance, and any other health/ medical plan, to issue payment directly to Radiology Imaging Associates, PC and/or its affiliates for medical service rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

_____ **AUTHORZIATION TO BILL INSURANCE.** I hereby authorize Radiology Imaging Associates, PC and its affiliates: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated during examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime.

_____ **COMMUNICATIONS CONSENT.** Radiology Imaging Associates PC, or its affiliates may use your information to contact you via telephone for appointment reminders or billing related inquiries, or to tell you about or recommend possible treatment options alternatives, and health-related benefits or services that may be of use to you.

_____ **ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES.** I acknowledge that I have been offered a copy of the Notice of Privacy Practices. I understand that the Notice of Privacy Practices is also electronically available on the RIA website. I understand this acknowledgment in no way affects the care I shall receive.

_____ **ACKNOWLEDGEMENT OF PHYSICAN OWNED ENTITY.** I acknowledge that I have been informed that RIA is a physician owned entity and that I have the option to choose where I receive my diagnostic imaging, interventional or neurovascular procedures. It will be my responsibility to inform RIA of where I want to have these procedures done at.

_____

Patient / Patient Representative Signature & Date

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Medical History Form

Please print all information.
Please correct label if applicable.

Patient Name_____ **DOB**_____ **MRN**_____
Chief Complaint (Reason for Visit) _____
_____

Females Are you pregnant or is there any reason to believe that you might be pregnant? ☐ Yes ☐ No ☐ Not Applicable

Surgical History ☐ **None**
Please identify surgeries _____
_____

Social History
Marital Status _____ Job/Career _____
Marijuana ☐None ☐Past ☐Present #of Years Smoked _____ #of Joints/mg per Day _____
Tobacco ☐None ☐Past ☐Present #of Years Smoked _____ #of Packs per Day _____
Alcohol Use ☐None ☐Yes, Use per Week _____Illicit Drug Use None ☐Yes, type and frequency_____

Family History of Medical Conditions

Mother _____ ☐Deceased
Brother_____ ☐Deceased
Sister _____ ☐Deceased
Grandparents_____

Father _____ ☐Deceased
Brother _____ ☐Deceased
Sister _____ ☐Deceased
Grandparents_____

ALLERGIES ☐No Known Drug Allergies
Medication _____ Reaction _____
Medication _____ Reaction _____
Medication _____ Reaction _____
Other(latex, adhesive, food, environment _____
Pharmacy Phone Number _____

MEDICATIONS ☐None
Please list any medications you are taking (including aspirin, vitamins, supplements or any other over the counter medication).

Name of Medication	Dose	How often do you take	Reason for taking medication

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Medical History Form

Please print all information.
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Patient Name_____ **DOB**_____ **MRN**_____

Cardiac

- ☐ Heart attack
  Date_____
- ☐ Congestive heart failure
- ☐ Heart murmur
- ☐ Fluid around heart
- ☐ Pacemaker
- ☐ High blood pressure
- ☐ Other_____
- ☐ **NONE**

Respiratory

- ☐ Pneumonia
- ☐ COPD/Emphysema
- ☐ Asthma
- ☐ Bronchitis
- ☐ Reactive airway
- ☐ Fluid around lungs
- ☐ Blood clots in lungs
- ☐ Dyspnea
- ☐ Sleep Apnea
- ☐ Other_____
- ☐ **NONE**

Neurological

- ☐ Headaches/Migraines
- ☐ CVA/Stroke/TIA
  Date_____
- ☐ Seizures
- ☐ Closed head injury/trauma
- ☐ Alzheimer's
- ☐ Aneurysm
- ☐ Parkinson's
- ☐ Multiple Sclerosis
- ☐ Other_____
- ☐ **NONE**

Eyes

- ☐ Vision Problems
- ☐ Left ☐ Right ☐ Both
- ☐ Problems with retina
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Other
- ☐ **NONE**

Ears/Nose/Throat

- ☐ Hearing Impairment
  ☐ Left ☐ Right ☐ Both
- ☐ Frequent sinusitis
- ☐ Other_____
- ☐ **NONE**

Circulatory/Hem/Lymph

- ☐ Left ☐ Right ☐ Both
- ☐ Peripheral vascular disease
- ☐ Claudication - Leg cramps with walking
- ☐ Blood clots in legs
  ☐ Left ☐ Right
- ☐ Blood Clots
- ☐ Blood clotting disorder (genetic)
- ☐ Other_____
- ☐ **NONE**

Endocrine

- ☐ Thyroid
- ☐ Diabetes Type I/II
- ☐ Oral ☐ Insulin
- ☐ Other_____
- ☐ **NONE**

Musculoskeletal

- ☐ Arthritis
  What type_____
  Where_____
- ☐ Fractures/Trauma
  What type_____
  Where_____
- ☐ Osteoporosis
- ☐ Gout
- ☐ Other_____
- ☐ **NONE**

Gastrointestinal

- ☐ Ulcers
- ☐ Colitis
- ☐ Crohn's Disease
- ☐ GI Bleeding
- ☐ Pancreatitis
- ☐ Hiatal Hernia
- ☐ Diverticulitis
- ☐ GERD
- ☐ Other_____
- ☐ **NONE**

- ☐ **Cancer**
  Type _____
- ☐ Current Treatment
- ☐ Other_____
- ☐ **NONE**

Gynecological

- ☐ Sexually transmitted disease
- ☐ Abn Pap Smear
- ☐ Endometriosis
- ☐ Other_____
- ☐ **NONE**

Genitourinary

- ☐ Prostate problem
- ☐ Kidney disease
- ☐ Dialysis
- ☐ Frequent urinary tract infections
- ☐ Kidney stones
- ☐ Acute Renal Failure
- ☐ Other_____
- ☐ **NONE**

Skin Disorders

- ☐ Eczema
- ☐ Rashes
- ☐ Herpes/Shingles
- ☐ Skin Cancer
- ☐ Other _____
- ☐ **NONE**

Psychosocial

- ☐ Mental health problems
- ☐ Depression
- ☐ Anxiety
- ☐ Addiction
- ☐ Other_____
- ☐ **NONE**

Pain

- ☐ Acute
- ☐ Chronic
- ☐ Treatment
- ☐ Pain Scale 1-10_____
- ☐ Other_____
- ☐ **NONE**

Infectious Disease

- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ HIV/AIDS
- ☐ MRSA
- ☐ Other
- ☐ **NONE**

_____

Female Only

- ☐ # Pregnancies_____
- ☐ # Live Births_____
- ☐ Other_____
- ☐ **NONE**