OPTIMA DIAGNOSTIC IMAGING

CT • MRI • PET/CT • BONE SCAN

ADVANCED TECHNOLOGY. UNSURPASSED CONVENIENCE.

Patient Information

Name: Last_____First_____Birth Date:_____/_____/_____

Address:_____Zip:_____Sex: ☐M ☐F

Home Phone:_____ Mobile Phone #: _____ Social Security # _____-_____-_____

Email address:_____ ☐ Please check box if, approved for PHI (Personal Health Information) use

How did you hear about Optima Diagnostic Imaging?

☐ Referring Doctor ☐ Family/Friend ☐ Internet ☐ Health Fair ☐ Saw an Ad ☐ Other

Name of Referrer or Location of Ad:_____

PHYSICIANS ARE REQUIRED BY FEDERAL GOVT AND/OR THE STATE OF CA TO REQUEST AND DOCUMENT THE FOLLOWING INFORMATION

Race: ☐ **Asian Indian, Pakistani** ☐ **Black** ☐ **Chinese** ☐ **Filipino** ☐ **Hawaiian** ☐ **Hispanic** ☐ **Japanese** ☐ **Native American**
☐ **Korean** ☐ **Vietnamese** ☐ **White** ☐ **Other** ☐ **Decline to Answer**

Ethnicity: ☐ **Hispanic or Latino** ☐ **Non-Hispanic or Latino** ☐ **Decline to Answer**

PREFERRED LANGUAGE _____

Employer:_____ Work Phone #:_____

Employer Address:_____

Relative or Friend Contact Information:

In the event you are unavailable to be contacted by our office, please indicate with **Yes or No** any family member or friend that we are able to release any or all information relating to your medical condition.

1) Name:_____Relationship: _____Phone #: _____☐Y ☐N

2) Name:_____Relationship: _____Phone #: _____☐Y ☐N

3) Name:_____Relationship: _____Phone #: _____☐Y ☐N

Assignment of Benefits and Acknowledgement

The undersigned authorizes, whether he/she signs as agent or as patient, direct payment to Optima Diagnostic Imaging of any insurance benefits otherwise payable to or on behalf of the undersigned for services rendered. It is understood by the undersigned that he/she is financially responsible for charges not fully satisfied by his/her insurance payment. This is to make you aware that your insurance company may deny payment for a multitude of reasons. Depending on your plan, your insurance can and may deny payments based on the coverage of your policy and may also leave you responsible for a certain portion. We do not know for certain until your insurance company is billed. Insurance companies do not guarantee payment until they have received your claim. If your claim is denied, Optima Diagnostic Imaging will resubmit the claim. After such resubmission, if the claim is still denied we will bill you for the procedure. The undersigned agrees to be personally and fully responsible for complete payment to Optima Diagnostic Imaging for all services and shall also be responsible for all attorneys' fees and collections costs incurred by Optima Diagnostic Imaging.

Print Name:_____ Signature:_____ Date:_____

Relationship if other than patient:_____

PATIENT COORDINATOR COPY

OPTIMA DIAGNOSTIC IMAGING

CT • MRI • PET/CT • BONE SCAN

ADVANCED TECHNOLOGY. UNSURPASSED CONVENIENCE.

IMAGING QUESTIONNAIRE

Date: _____

Name: _____ D.O.B:_____HT: _____ WT: _____Sex:_____

Ref. Physician: _____Next appointment with doctor:_____

Allergies: _____Iodine/Shellfish_____

Medical History (please mark all that apply):

☐ Cardiac Pacemaker	☐ IUD	☐ Seizure Disorder
☐ Brain aneurysm clips	☐ Heart Disease	☐ Shortness of Breath
☐ Aortic Clips	☐ High Blood Pressure	☐ Artificial heart valve
☐ Electrodes	☐ Implanted Device	☐ Stroke
☐ Cancer	☐ Thyroid Disorder	☐ Joint replacement
☐ Cochlear implants	☐ Kidney/Liver Disease	☐ Family History of Anesthesia Problems
☐ Asthma	☐ Internal Catheter	☐ Family History of Kidney Disease
☐ Dentures	☐ Insulin Pump	☐ Metal Mesh
☐ Arthritis	☐ Neurological Disorder	☐ Chemotherapy
☐ Dialysis	☐ Metal slivers in the eye	☐ Hearing aids
☐ Radiation Therapy	☐ Colostomy/Ileostomy	☐ Drains/Open Wounds

☐ Other/ Location (please list)_____

Additional Patient Information:

Claustrophobic? (Yes / No) Do you have any metal in your body (Plates, Screws, Pins, clips etc..) ? (Yes / No)

Hx Of Cancer? (Yes/No) Pregnant (Yes/No) Pacemaker (Yes/No)

Are you diabetic? (Yes/No) if Yes, and taking Metformin, it must be discontinue for 48 hours.

Have you had anything to eat today? (Yes/No) When:_____

Medications (Dose)?_____

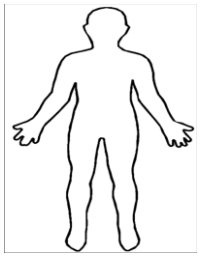
Previous surgeries/studies to the **body part** we are scanning? (Yes / No) If yes,explain_____

_____

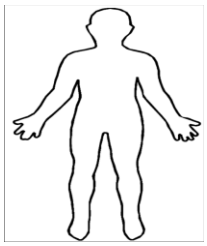
Briefly describe your symptoms in relation to today's Scan: _____

_____

Please mark (X) where the pain is located:



(front)



(back)

Does this pain go down your:		
Arm	Right	Left
Leg	Right	Left
Other _____	Right	Left

Signature: _____

(PLEASE REMOVE ALL JEWELRY !)

01/2011 TG

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 AS REQUIRED BY THE PRIVACY REGULATIONS CREATED AS A RESULT OF THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY

We understand that medical information about you is personal. We are committed to protecting medical information about you. Each time you visit a hospital, physician or other healthcare provider, a record of your visit is made. This notice applies to all of the records of your care that we maintain, whether created by facility staff or your personal physician.

As required by law, we will:

- keep medical information about you private;
- provide, or make available, as applicable, this notice of our legal duties and privacy practices with respect to medical information about you; and follow the terms of the notice that is currently in effect.

Obtain a copy of this notice
You have the right to a current copy of this notice. You may obtain a copy of this notice any time in person or by written request

How we may use and disclose medical information about you
We will share medical information about you for purposes of treatment, such as sending medical information about you to your physician or specialist as part of a referral, to obtain payment for treatment, and to support health care operations.

We may use health information about you without prior authorization for several other reasons. Subject to applicable law to carry out their duties, we may give out medical information about you to other entities for:

- public health authorities that are authorized by law to collect the information (such as, births, deaths, public surveillance)
- abuse, neglect or domestic violence reporting when it is a threat to your safety and the safety of another individual or the public
- health oversight audits or inspections
- research studies
- workers' compensation purposes
- emergencies
- requests from law enforcement, or in response to valid judicial or administrative orders

Your rights regarding medical information about you
You have the right to look at or get a copy of medical information that we use to make decision about your care. We will provide you with a form you can complete to make the request. If you request copies, however, we may charge a fee for copying, mailing and other related supplies. If we deny your request to review or obtain a copy, you may submit a written request for review of that decision.
You have the right to request us to amend your health information if you believe it is incorrect or missing. We will provide you a form which you can complete to make the request. We may deny your request to amend a record if the information was not created by us, if it is not part of medical information maintained by us, or if we determine that the record is accurate. If we deny your request to amend, you may submit a request to review that decision by us not to amend the record.
You have the right to make a written request to us for a list of instances where we have disclosed medical information about you other than for treatment, payment, health care operations or where you specifically authorized disclosure.
You have the right to request that medical information about you be communicated to you in a confidential manner.
You may request, in writing, that we not use or disclose medical information about you for treatment, payment or healthcare operations or to persons involved in your care except when specifically authorized by you, when required by law, or in an emergency. We will consider your request but our processes may not be able to accommodate it and we are not legally required to accept it. We will inform your of our decision on your request.

All written requests for review of denials should be submitted to our Privacy Officer

Other uses of medical information
In any other situation not cover by this notice, we will ask for your written authorization before using or disclosing medical information about you. If we request and obtain your authorization to use or disclose your medical information, you can later revoke authorization by notifying us in writing.

Complaints
If you are concerned that your privacy rights may have been violated, or you disagree with a decision we made about access to your records, you may contact our Facility Privacy Office in writing. Finally, you may send a written complaint to the U.S. Department of Health and Human Services Office of Civil Rights. Under no circumstance will you be penalized or retaliated against for filing a complaint.

If you have any questions regarding this Notice of Privacy Practices please contact us at

Optima Diagnostic Imaging, 8900 Wilshire Blvd., Beverly Hills, CA 90211, or call 310-432-8900.

Patient HIPAA Statement

I understand as part of my healthcare, the Optima Diagnostic Imaging originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand this information serves as:

- A basis for planning my care and treatment;
- A means of communication among the many health professionals who contribute to my care;
- A source of information for applying my diagnosis and health information for billing purposes;
- A means by which a third-party payer can verify that services billed were actually provided;
- And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I acknowledge that I have received, read, and understand Optima Diagnostic Imaging's *Notice of Privacy Practices*, which provides a more complete description of information uses and disclosures. I have the right to review this notice prior to signing this consent. I understand the organization reserves the right to change their notice and practices at any time and I may request a copy of any revised notice by contacting our Privacy Officer at (310) 432-8900.

I understand I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that this organization is not required to agree to the restrictions requested.

This acknowledgement is given freely with the understanding that any and all records, whether written, oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as authorized by law. A photocopy or fax of this consent is as valid as this original.

Print Patient's Name _____ Date _____

Patient's Signature (or personal representative) _____ Date _____

PATIENT COORDINATOR COPY

Authorization for Release of Medical Records

I hereby authorize: _____

To release the following information from my medical records: to Optima Diagnostic Imaging *OR* to _____

Patient Name: _____

Date of Birth: _____/_____/_____

Records Specifically Requested:

- ☐ Surgery Report(s)
- ☐ Pathology Report(s)
- ☐ Imaging Report(s) including X-Ray, CT, MRI, Nuclear Medicine
- ☐ Consultation Report including History & Physical
- ☐ Radiation Therapy Records (if any)
- ☐ Chemotherapy Records (if any)
- ☐ Most recent Follow-up record
- ☐ Other:_____

Print Name:_____

Patient Signature:_____Date:_____/_____/_____

Please forward records to:

Optima Diagnostic Imaging
8900 Wilshire Blvd.
Beverly Hills, CA 90211
TEL: (310) 432-8999
FAX: (310) 432-8995

PATIENT COORDINATOR COPY