OPTIMUM IMAGING

www.optimumimaging.com

Name:_____ ___ _____ DOB: ___ - ___ - _____
First M Last

Email:_____ Sex: ☐Female ☐Male

Address:_____ _____ _____ _____
Street/ P.O. Box City State Zip Code

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Race: ☐ American/Alaskan Indian ☐Asian ☐Black / African American ☐White / Caucasian ☐Other

Home Phone:_____Cell Phone:_____Additional:_____

Employer Name:_____ Phone:_____

Employer Address:_____ _____ _____ _____
Street/ P.O. Box City State Zip Code

Insurance Name:_____

Policy ID#:_____ Policy Group#:_____

Primary Card Holder Name:_____DOB: ___ - ___ - _____

** We require a copy of your insurance and valid driver license or Texas ID **

Is patient allergic to Iodine: ☐Yes ☐ No ■ Unsure

Medical Doctor:_____ Phone:_____

Who should we thank for referring you:_____

Emergency Contact:_____

Phone:_____ Relationship:_____

I shall be responsible to pay **OPTIMUM IMAGING CENTER,** for professional services. I realize that insurance is a courtesy and not a guarantee of payment for services. I guarantee payment for services rendered. I hereby authorize payment of medical benefits to the supplier for medical services rendered. I also hereby authorize release of medical records to my insurance company and other medical providers.

Please note: Radiologist Reading Will Be Billed Separately to Insurance. _____ **(Please initial)**

_____ Date: ___ - ___ - _____
Patient Signature

1300 S Bryan Road, Ste. 104
Mission, Tx 78572
Tel: (956) 583 - 0004
Fax: (956) 583 – 5790

500 S Bicentennial Blvd., Ste. 100-B
McAllen, Tx 78501
Tel: (956) 585-8700
Fax: (956) 215-7511

OPTIMUM IMAGING

www.optimumimaging.com

PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule: to help ensure that personal health care information is protected for privacy. The Privacy rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patients we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your healthcare operations, in order to provide health and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients) and may have to disclose personal health information for purposes of treatment, payment or healthcare operations. These entities are most often not required to obtain patient consent.

You may refuse consent to the use or disclosure of your personal health information, but this must be in writing. Under the law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all of part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this for, please ask to speak with our HIPPA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name:_____ Signature:_____ Date: ____ - ____ - _____

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To Our Valued Patients:

The misuse of Personal Health Information (PHI) had been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers, and doctors regarding the Health Insurance Portability and Accountability Act (HIPPA) with particular emphasis on the "Privacy Rule. 'We strive to achieve that very highest standard of ethics and integrity in performing services for our patients.

It is policy to properly determine appropriate use of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any though of penalization if they feel than an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients

1300 S Bryan Road, Ste. 104
Mission, Tx 78572
Tel: (956) 583 - 0004
Fax: (956) 583 – 5790

500 S Bicentennial Blvd., Ste. 100-B
McAllen, Tx 78501
Tel: (956) 585-8700
Fax: (956) 215-7511

OPTIMUM IMAGING

www.optimumimaging.com

AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

Name:_____ ____ _____ DOB: ___ - ___ - ____
First M Last

Address:_____ _____ _____ _____
Street/ P.O. Box City State Zip Code

I authorize **OPTIMUM IMAGING CENTER** to release the following medical information to:

Name of person / facility:_____

Address:_____ _____ _____ _____
Street/ P.O. Box City State Zip Code

Check all studies that may be released:

☐ DXA
☐ X-Ray
☐ CT Scan
☐ Ultrasound
☐ MRI
☐ MAMMOGRAPHY

☐ Other: _____

This authorization covers patient care given from: ___ - ___ - ____ to: ___ - ___ - ____

Purpose for disclosure:

☐ Medical Care
☐ Insurance
☐ Attorney
☐ Other:_____

This authorization shall be valid 60 days from the date of signature. This patient can revoke this authorization in writing at any time prior to the expiration date.

This patient agrees that a photocopy of this authorization may be considered valid.

☑ Yes
☐ No

Patient Signature:_____

Date: ___ - ___ - ____ Witness Signature:_____

1300 S Bryan Road, Ste. 104
Mission, Tx 78572
Tel: (956) 583 - 0004
Fax: (956) 583 – 5790

500 S Bicentennial Blvd., Ste. 100-B
McAllen, Tx 78501
Tel: (956) 585-8700
Fax: (956) 215-7511

OPTIMUM IMAGING

www.optimumimaging.com

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Name:_____ ____ _____ DOB: ____ - ____ - _____
First M Last

I acknowledge that Optimum Imaging Center provided me with a written copy of his / her **Notice of Privacy Practices.**

I also acknowledge that I have been afforded the opportunity to read the Notice of Practices and ask questions.

_____ Date: ____ - ____ - _____

Patient Signature

1300 S Bryan Road, Ste. 104
Mission, Tx 78572
Tel: (956) 583 - 0004
Fax: (956) 583 – 5790

500 S Bicentennial Blvd., Ste. 100-B
McAllen, Tx 78501
Tel: (956) 585-8700
Fax: (956) 215-7511