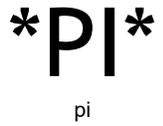


**FOR OFFICIAL WASHINGTON RADIOLOGY USE ONLY
PLACE PATIENT LABEL HERE**



SHADED FIELDS ARE MANDATORY

WE ARE EXCITED TO ANNOUNCE THAT WE HAVE TRANSITIONED TO A NATIONALLY CERTIFIED ELECTRONIC HEALTH RECORDS KEEPING SYSTEM (EHR). AS PART OF THIS CHANGE, WE ARE REQUESTING ADDITIONAL PATIENT DATA THAT WILL HELP US FULLY UTILIZE THE EHR. ADDITIONALLY, WE ARE ASKING FOR PATIENT DEMOGRAPHIC INFORMATION (SUCH AS RACE AND ETHNICITY) THAT IS REQUIRED BY THE GOVERNMENT FOR US TO MAINTAIN OUR PARTICIPATION WITH FEDERAL INSURANCE PROGRAMS, INCLUDING MEDICARE. WE HAVE TAKEN APPROPRIATE MEASURES TO COMPLY WITH HEALTHCARE PRIVACY AND SECURITY REGULATIONS. WE HAVE POLICIES, PROCEDURES, AND SAFEGUARDS IN PLACE TO PREVENT UNAUTHORIZED ACCESS TO OUR PATIENTS' RECORDS. WE ALSO HAVE PROVISIONS FOR BACKUP AND DISASTER RECOVERY OF YOUR MEDICAL RECORD IN CASE OF FIRE, WATER DAMAGE, ETC. WE APPRECIATE YOUR COOPERATION AND PATIENCE IN COMPLETING THIS FORM!

LAST NAME, FIRST NAME MI		DATE OF BIRTH	GENDER
RACE <input type="checkbox"/> AMERICAN INDIAN OR ALASKA NATIVE <input type="checkbox"/> ASIAN <input type="checkbox"/> BLACK OR AFRICAN AMERICAN <input type="checkbox"/> NATIVE HAWAIIAN OR PACIFIC ISLANDER <input type="checkbox"/> WHITE <input type="checkbox"/> OTHER <input type="checkbox"/> DECLINE TO ANSWER			
ADDRESS		APT NO	CITY, STATE ZIP
HOME PHONE	WORK PHONE	CELL PHONE	EMAIL ADDRESS
CONTACT PREFERENCE: <input type="checkbox"/> MOBILE <input type="checkbox"/> HOME <input type="checkbox"/> WORK		CIRCLE ONE: I AGREE / I DO NOT AGREE TO ALLOW ELECTRONIC COMMUNICATION VIA EMAIL/TEXT	
EMPLOYER OR SCHOOL NAME			
EMERGENCY CONTACT NAME		EMERGENCY CONTACT PRIMARY PHONE	RELATIONSHIP
DO YOU SPEAK ENGLISH? <input type="checkbox"/> YES <input type="checkbox"/> NO		OTHER LANGUAGES SPOKEN	
SMOKING STATUS <input type="checkbox"/> SMOKE EVERY DAY <input type="checkbox"/> SMOKE BUT ONLY SOME DAYS <input type="checkbox"/> FORMER SMOKER <input type="checkbox"/> HEAVY SMOKER <input type="checkbox"/> LIGHT SMOKER <input type="checkbox"/> NEVER SMOKED			
ETHNICITY <input type="checkbox"/> HISPANIC OR LATINO <input type="checkbox"/> NON HISPANIC		HEIGHT FT IN	WEIGHT LBS
		ESTIMATED BLOOD PRESSURE SYSTOLIC DIASTOLIC	
LIST ALLERGIES	SEVERITY (MILD, MODERATE, SEVERE)	LIST CURRENTLY PRESCRIBED MEDICATIONS	
CAN YOU STAND UNASSISTED FOR A MINIMUM OF 10 MINUTES?	<input type="checkbox"/> YES <input type="checkbox"/> NO	WHAT TYPE OF SUPPORT DO YOU REQUIRE FOR STANDING AND WALKING? (I.E. CANE, WALKER, ADDITIONAL PERSON, HOYER LIFT, OTHER, NONE)	
HAVE YOU FALLEN IN THE PAST 6 MONTHS?	<input type="checkbox"/> YES <input type="checkbox"/> NO		

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME	POLICY NUMBER	GROUP NUMBER	NAME OF PRIMARY POLICY HOLDER	POLICY HOLDER DOB	RELATIONSHIP TO PATIENT
SECONDARY INSURANCE COMPANY NAME	POLICY NUMBER	GROUP NUMBER	NAME OF PRIMARY POLICY HOLDER	POLICY HOLDER DOB	RELATIONSHIP TO PATIENT

PHYSICIAN INFORMATION

REFERRING PHYSICIAN NAME AND ADDRESS
OTHER PHYSICIAN NAME AND ADDRESS

EXAM INFORMATION

DATE AND DESCRIPTION OF PRIMARY EXAM AND REASON

PATIENT AUTHORIZATIONS

1) I HEREBY AUTHORIZE WASHINGTON RADIOLOGY TO APPLY FOR HEALTHCARE BENEFITS ON MY BEHALF FOR THE SERVICES RENDERED. I REQUEST THAT THE PAYMENTS FROM ANY GOVERNMENT-SPONSORED HEALTHCARE PROGRAM, INSURANCE COMPANY, OR INDEPENDENT CARRIER WITH WHICH WRA CONTRACTUALLY PARTICIPATES BE MADE DIRECTLY TO WR. I CERTIFY THAT THE INSURANCE INFORMATION ABOVE IS CORRECT.

2) I AUTHORIZE THE RELEASE OF ANY MEDICAL RECORDS TO WASHINGTON RADIOLOGY AS REQUIRED BY THE MQSA TO MAINTAIN ACCREDITATION.

3) I AUTHORIZE RELEASE OF ANY NECESSARY INFORMATION, INCLUDING PROTECTED HEALTH INFORMATION (PHI) FOR THIS OR ANY OTHER CLAIM, TO ANY GOVERNMENT-SPONSORED HEALTHCARE PROGRAM, INSURANCE COMPANY, OR INDEPENDENT CARRIER FOR THE PURPOSE OF OBTAINING REIMBURSEMENT FOR THE SERVICES RENDERED. IN ADDITION TO HEALTH INSURANCE COMPANIES AND TREATING PHYSICIANS, I FURTHER AUTHORIZE RELEASE OF MY MEDICAL INFORMATION TO:

NAME	RELATIONSHIP
NAME	RELATIONSHIP

I UNDERSTAND THAT I HAVE THE RIGHT TO RECEIVE, UPON REQUEST, A COPY OF WRA'S NOTICE OF PRIVACY PRACTICES WHICH DESCRIBES HOW WR MAY DISCLOSE MY PHI. FAILURE TO PROVIDE REQUESTED INFORMATION, OR TO AUTHORIZE RELEASE OF PHI, MAY RESULT IN NON-PAYMENT OF MY CLAIM BY MY INSURANCE COMPANY. I FURTHER ACKNOWLEDGE THAT ALL SERVICES RENDERED ARE THE FINANCIAL LIABILITY OF THE PATIENT OR GUARANTOR AND I MAY BE HELD LIABLE FOR WRA'S FEES DUE TO NON-PAYMENT BY MY INSURANCE COMPANY. PATIENTS WITH A CREDIT BALANCE WITH WR MANAGEMENT AGREE TO APPLY CREDIT BALANCE TO ANY OPEN CHARGES. I ALSO PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL. THESE AUTHORIZATIONS MAY BE REVOKED BY ME, IN WRITING, AT ANY TIME.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN	DATE
---	------