

FOR OFFICIAL WR 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			
ADDRESS		APT NO	CITY, STATE ZIP
HOME PHONE	WORK PHONE	CELL PHONE	EMAIL ADDRESS
PREFERRED NOTIFICATION METHOD (SELECT ONE ONLY)			
<input type="checkbox"/> EMAIL <input type="checkbox"/> MAIL <input type="checkbox"/> CALL HOME <input type="checkbox"/> CALL MOBILE <input type="checkbox"/> CALL WORK			
EMPLOYER OR SCHOOL NAME			
EMERGENCY CONTACT NAME			RELATIONSHIP
EMERGENCY CONTACT PRIMARY PHONE		CONTACT'S WORK PHONE EXT	CONTACT'S ALT PHONE
DO YOU SPEAK ENGLISH?		OTHER LANGUAGES SPOKEN	
<input type="checkbox"/> YES <input type="checkbox"/> NO			
SMOKING STATUS			
<input type="checkbox"/> CURRENTLY SMOKE EVERY DAY <input type="checkbox"/> CURRENTLY SMOKE BUT ONLY SOME DAYS <input type="checkbox"/> FORMER SMOKER <input type="checkbox"/> NEVER SMOKED			
ETHNICITY		HEIGHT	WEIGHT
<input type="checkbox"/> HISPANIC OR LATINO <input type="checkbox"/> NON HISPANIC		FT IN	LBS
		ESTIMATED BLOOD PRESSURE	
		SYSTOLIC	DIASTOLIC
LIST ALLERGIES	SEVERITY (MILD, MODERATE, SEVERE)	LIST CURRENTLY PRESCRIBED MEDICATIONS	
		DOSAGE	

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME	POLICY	GROUP
SECONDARY INSURANCE COMPANY NAME	POLICY	GROUP

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 WR 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 WR 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 WR'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 WR'S FEES DUE TO NON-PAYMENT BY MY INSURANCE COMPANY. 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
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