FOR OFFICIAL WRA USE ONLY
PLACE PATIENT LABEL HERE

PATIENT INFORMATION

WASHINGTON RADIOLOGY

pi

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	SOC SEC NUMBER	DATE OF BIRTH	GENDER

RACE

☐ AMERICAN INDIAN OR ALASKA NATIVE ☐ ASIAN ☐ BLACK OR AFRICAN AMERICAN ☐ NATIVE HAWAIIAN OR PACIFIC ISLANDER ☐ WHITE

ADDRESS	APT NO	CITY, STATE ZIP

HOME PHONE	WORK PHONE	CELL PHONE	EMAIL ADDRESS

PREFERRED NOTIFICATION METHOD (SELECT ONE ONLY)

☐ EMAIL ☐ MAIL ☐ CALL HOME ☐ CALL MOBILE ☐ 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
☐ YES ☐ NO	

SMOKING STATUS

☐ CURRENTLY SMOKE EVERY DAY ☐ CURRENTLY SMOKE BUT ONLY SOME DAYS ☐ FORMER SMOKER ☐ NEVER SMOKED

ETHNICITY	HEIGHT	WEIGHT	ESTIMATED BLOOD PRESSURE
☐ HISPANIC OR LATINO ☐ NON HISPANIC	FT IN	LBS	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 ASSOCIATES (WRA) 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 WRA. I CERTIFY THAT THE INSURANCE INFORMATION ABOVE IS CORRECT.
2) I AUTHORIZE THE RELEASE OF ANY MEDICAL RECORDS TO WRA 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 WRA 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. 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