RIVER RANCH RADIOLOGY™

PATIENT INFORMATION RECORD

This form must be filled out completely & legibly, With special attention to the highlighted areas.

Patient Name: ____
First Middle or Maiden Last

Social Security Number: ____________ Date of Birth: ________ Gender: Male Female Other

Address: ____
Street City State Zip

Phone: ____________ Alternate phone: ____________ Business phone: ____________

Email: ______________________ *(we may use your email address to contact you regarding information about your appointment)*

CONTACT IN CASE OF EMERGENCY: ______________________ **PHONE:** ____________

Patient's Employer: ____

Business Address: ____
Street City State Zip

Were you injured on the job? Yes No If yes, give date of injury: ____________

INSURANCE:

1. Primary Insurance Company Name: ______________________
   Address: ______________________
   I.D.: ____________ Group #: ____________ Employer: ____________
   Name of Insured: ______________________ Relation to Patient: ____________
   Social Security Number: ______________________ Date of Birth: ____________
2. Secondary Insurance Company Name: ______________________
   Address: ______________________
   I.D.: ____________ Group #: ____________ Employer: ____________
   Name of Insured: ______________________ Relation to Patient: ____________
   Social Security Number: ______________________ Date of Birth: ____________

If the insurance listed above is under your spouse's name, please complete the employment section below.

Spouse's Name: ______________________ Business Phone: ____________

Employer: ____

IF PATIENT IS A MINOR:
Parent or Guardian

Name: ____________ Home Phone: ____________ Business Phone: ____________

Address: ____

Social Security Number: ______________________ Employer: ____________

RELEASE OF INFORMATION/ASSIGNMENT OF BENEFITS
I hereby authorize the release of my medical records, inclusive of all results of my testing and other pertinent information acquired during my treatment, to River Ranch Radiology and other physicians as deemed necessary. I agree that a photocopy of this authorization shall be considered as effective and valid as the original. I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private and group insurance, or other health plan to: River Ranch Radiology.

FINANCIAL RESPONSIBILITY
Unless prohibited by Medicare, Medicaid, or any other federal or state health care law or program, I accept ultimate financial responsibility for accounts with River Ranch Radiology whether paid by insurance or not. For example, if the diagnostic and therapeutic treatment performed at River Ranch Radiology is related to a workers' compensation claim and my injury is finally adjudicated not compensable under the Texas Workers'Compensation Act (the "Act"), I acknowledge that I will be resposible to River Ranch Radiology for payment of all accounts related to such diagnostic and therapeutic treament pursuant to § 413042 of the Act.

______________________ ____________ ______________________
Signature of Patient / Parent or Guardian Date Signature of Witness

RIVER RANCH RADIOLOGY™

PATIENT QUESTIONNAIRE

Patient Name:__________ Height:______ Weight:______ Age:______

Physician treating your symptoms:__________ Patient Sex: ______

Today's exam is of what body part:__________ Date of Birth______

What symptoms are you having?__________

If applicable, are your symptoms left sided, right sided or both?__________

Date of injury or onset of symptoms:__________

List **all** medications you are currently taking:__________

Y N Have you had any of the following? If yes, please explain:

1. Cancer or tumor?______
2. Chemotherapy or radiation? ______
3. Injection of iodine contrast (x-ray dye)?______
a. Did you have a reaction (with the exception of sensation of heat, flushing, or single episode of nausea or vomiting)?______
4. Allergy history or condition? ______
5. Lung Problems?______
a. Emphysema? ______
b. Bronchitis? ______
c. Asthma history or condition? ______
d. Shortness of breath? ______
6. Diabetes? ______
a. Insulin dependent? ______
b. Controlled by diet? ______
c. Glucophage? ______
7. Heart problems?______
a. Angina? (chest pain) ______
b. Irregular pulse? ______
c. Fainting spells? ______
d. Significant cardiac dysfunction, including recent or imminent decompensation? ______
e. Severe arrhythmia? ______
f. Unstable angina pectoris? ______
g. Infarction? (heart attack) ______
h. Pulmonary hypertension? ______
8. Seizures? ______
9. Kidney disease, kidney failure or dialysis?______
10. Sickle cell anemia?______
11. Mastectomy? ______
12. Surgery? ______
a. Spinal Surgery? ______
13. Generalized debilitation (weakness)? ______
14. Do you currently have any indwelling catheter used for IV therapy? ______
15. Do you have a history of TB or a prolonged cough? ______
16. Did you drink any barium or oral prep? ______
17. Do you have any cultural or religious practices we need to consider?______
18. Do you have any questions about your above procedure?______

FOR FEMALE PATIENTS ONLY

a. Last menstrual date:______
b. Are you pregnant or trying to get pregnant?______ **c.** Estimated due date: ______
d. Are you nursing? ______

Have you had previous radiological scans related to your current problem? YES NO Did you bring any films with you? YES NO
If you answered **YES,** please fill in the boxes below.

	Body Part	Date of Exam	Facility & Location
CT Scan			
MRI			
X-ray			
Bone Scan			
Ultrasound			
Myelogram			
Angiogram			

Do you have a follow up appointment scheduled with your doctor? YES NO Date:______ **Time:**______

Patient Signature:______ **Date:**______ **RRR Tech:**______

RIVER RANCH RADIOLOGY™

Authorization Form for Procedures

Patient Name: ____________________ Date: ____________________

PROCEDURE MRI CT X-RAY IVP ARTHROGRAM BARIUM STUDY
ULTRASOUND LUMBAR PUNCTURE BONE DENSITOMETRY MYELOGRAM

Scanning Facility

Supervision of the scanning procedure, as well as interpretation of the scan, is the responsibility of the radiologist on site or any radiologists associated with River Ranch Radiology (heretofore referred to as *The Radiologists*). River Ranch Radiology does not control the manner or method by which *The Radiologists* supervise the scanning procedures and interprets the scans. Therefore, River Ranch Radiology is not responsible for the acts or omissions of *The Radiologists*.

Medical Coverage

All medical coverage in connection with the scan will be the responsibility of *The Radiologists*. This includes the administration of contrast solution, sedatives or any other medical treatment necessary during and following the scan. *The Radiologists* are not employees of River Ranch Radiology, but provide medical coverage through a contract with River Ranch Radiology. Again, River Ranch Radiology is not responsible for the acts or omissions of *The Radiologists* in connection with this medical coverage.

Authorization & Consent

1. **Procedure**
   I authorize and consent to the above named procedure, which will be performed on me at River Ranch Radiology. This procedure will involve the use of an imaging device and **may** include a contrast solution to be injected and/or sedation. In the event of any complication, I authorize the on-site physician to provide me with cardiopulmonary resuscitation (CPR) or emergency medical services (EMS).

2. **Intravenous Contrast / Oral Sedation**
   I have been informed that contrast may be used in this procedure because it enables the radiologist to better view and diagnose abnormalities that may otherwise go undetected. River Ranch Radiology is committed to using only the safest contrast agents available. However, adverse reactions can occur with the injection of contrast. I understand these uncommon but possible reactions can include hives, pain, hot flashes, breathing difficulties and in very rare occasions cardiopulmonary arrest which could result in death. *MRI contrast (Gadolinium) has not received FDA approval for use in patients under 2 years of age*

   Instructions following IV Contrast
   Drink plenty of fluids after your scan to assist the body in ridding itself of the contrast. In the event that any of the above reactions occur, please call River Ranch Radiology at (512) 454-9597. In the event of an emergency, do not call River Ranch Radiology. CALL 9-1-1 immediately.

   Instructions following Oral Sedation
   For twelve (12) hours following your examination, you must adhere to the following instructions: do not drive a car; do not operate heavy machinery; do not consume alcohol; and do not sign legal documents.

3. **Fees**
   Unless prohibited by Medicare, Medicaid, or any other federal or state health care law or program, I accept responsibility for scanning fees at the contractually negotiated rate. My portion today is **estimated** at $______________

4. **Personal Valuables**
   I understand that River Ranch Radiology will provide lockers for storage of my property. River Ranch Radiology does not assume any responsibility for loss of property or valuables.

5 **Acknowledgement**
   I, ______________________________(patient name), acknowledge that I have received a copy of River Ranch Radiology's Notice of Privacy Practices.

I have read and understand the above consent. I have been given the opportunity to ask questions about the purpose and nature of the procedure and the possible associated risks. I accept all responsibility for the risks or complications, which might occur during and after these procedures.

Signature of Patient or Responsible Adult ____________________ Relationship to Patient ____________________

Witness ____________________ Date ____________________

If you have any questions, please fee free to contact River Ranch Radiology Monday-Saturday 8:00 a.m. to 5:00 p.m. at (512) 454-9597 or (800) 394-7226. In the event of an emergency call 911.

PROTECTED HEALTH INFORMATION CONSENT FORM

River Ranch Radiology (RRR) has implemented a secured electronic archive called a picture archiving and communication system (PACS). This web-based system allows your treating physician(s) and treatment staff to access the results of your exam. This system was designed to improve overall quality patient care and the timeliness of results available for your treatment.

In order to maintain compliance with federal and state laws, RRR has developed several safeguards to protect our patients' protected health information (PHI). Prior to receiving access to RRR's PACS system, your treating physician(s) and treatment staff must agree to the following:

- Utilize the system for the sole purpose of treating and diagnosing their patients only and for no other purpose except those allowed by federal and state laws
- Implement appropriate safeguards to prevent the use or disclosure of PHI to unauthorized persons
- Use appropriate safeguards to protect their user name and password from unauthorized access
- Report any unauthorized use to RRR's privacy officer

In addition to the safeguards above, RRR will do the following to protect your PHI:

- Monitor usage of the PACS system for traffic and unauthorized activity
- Utilize Secure Socket Layer (SSL) encryption for the PACS web-based system

It is important for you to understand that although we have implemented the systems above to protect your PHI, River Ranch Radiology cannot guarantee full compliance. Potential threats may include, but are not limited to:

- Other physicians and staff may view your PHI if they violate the security agreement.
- A treating physician and/or treatment staff may leave their password in an unprotected area in which unauthorized users may see it.
- A treating physician and/or treatment staff may also leave their workstations unattended while logged into the PACS system, which would allow unauthorized parties access to the system.

By signing below you agree to the following:

- I have read and understand the contents of this consent form.
- I understand the potential threats associated with having my PHI on the PACS system.
- I understand that my treating physician is solely responsible for any liability in which my PHI was disclosed to unauthorized persons.
- I will not hold River Ranch Radiology liable for any breach of my PHI unless it is due to RRR's own negligence.
- I understand my PHI may be disclosed for the treatment, payment, and healthcare operations as outlined in the Notice of Privacy Practices.
- River Ranch Radiology reserves the right to refuse service to any patient who refuses to sign this consent form. If I choose not to sign, RRR may not perform my exam unless it is an emergent situation or required by federal and state law.
- I may submit written request to revoke this authorization to the River Ranch Radiology privacy officer.

I also understand that written adjustments to this consent form will not be considered binding and therefore not accepted.

______________________________	____________________	____________
Signature of patient or authorized representative	Relationship to patient	Date

______________________________	____________________
Witness	Date

RIVER RANCH RADIOLOGY

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. PLEASE REVIEW CAREFULLY.

Our Duties

We are required by law to maintain the privacy of your medical information and to provide you with notice of our legal duties and privacy practices. We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change those terms and any changes made will be effective for all medical information we maintain. A copy of a revised notice will be available from our website www.riverranchradiology.com, at our imaging centers, or from our Privacy Coordinator by calling (512) 454-9598 ext. 555 or by writing to River Ranch Radiology, 711 West 38th Street, Suite D-1, Austin, Texas 78705, Attention: Privacy Coordinator. You may also address questions regarding our privacy practices, your privacy rights, or requests for additional information regarding your privacy to this person.

Permitted Uses

We may use and disclose your medical information for specific reasons:

- Treatment: We will provide your doctor or other health care provider with the results of the diagnostic imaging exams we perform. Your information will also be shared with our independent physicians supervising or interpreting your imaging procedures. We may contact you before the exam to remind you of your appointment or to talk with you about preparing for the exam. We may also use a sign-in sheet to identify your presence for an appointment and call you by name when it is time for your appointment.
- Payment: We will bill your insurance company, you directly, or another person that may be responsible for payment of your account. We may need to contact your health plan to see if they will pay for the exam(s) your doctor has ordered.
- Health Care Operations: We routinely review past exams performed to maintain quality assurance goals. That means that we may select your images for review by another radiologist. We may also select your billing information for review by our internal compliance department or by external auditors. In the event your information is shared with a third party “business associate”, we will have a written contract that contains terms that will protect the privacy of your protected health information.

Disclosures without Authorization

We may use and disclose medical information about you, without your specific authorization:

- Required by Law: We may use and disclose information about you for judicial and administrative proceedings pursuant to a legal authority; to report information related to victims of abuse, neglect or domestic violence; and to assist law enforcement officials in their law enforcement duties to the extent consistent with Texas and federal law.
- Public Health Activities: We may disclose your medical information for public health activities such as assisting public health authorities or other legal authorities to prevent or control disease, injury, or disability, or for other health oversight activities.

- Research: We may use your health information for research purposes when an institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of your health information.
- Health and Safety: Pursuant to applicable law, your health information may be disclosed to avert a serious threat to the health or safety of you or any other person.
- Government Functions: Specialized government functions such as protection of public officials or reporting to various branches of the armed services may require use or disclosure of your health information to the extent consistent with Texas and federal law.
- Workers' Compensation: We may disclose your health information in order to comply with laws and regulations related to Workers' Compensation.

Patient Rights

You have certain rights with respect to your medical information.

Requesting Restrictions: You may ask us to limit our use or disclosure of your protected health information. We are not required to agree to your request, but if we agree to it, we will abide by your request except as required by law. In emergencies, or when the information is necessary to treat you. Your request must: 1) be in writing, 2) describe the information that you want restricted, 3) state if the restriction is to limit our use or disclosure, and 4) state to whom the restriction applies.

Confidential Communications: You may ask that we communicate with you in a particular way, or at a certain location, to maintain your confidentiality. Your request must be in writing and must tell us how you intend to satisfy your financial responsibility and specify an alternate way that we can contact you confidentially. You do not have to give a reason for your request.

Inspect and Copy: You may request access to inspect and copy your medical information maintained in our records, including medical and billing records. Your request must be in writing. We will act on your request within fifteen (15) days after we receive it. If we must deny your request, we will send you a written denial. If this happens, you may request a review of the denial. We may charge you a fee for this service.

Amendment: You may ask us to amend your health information if you believe that it is incorrect or incomplete. Your request must be in writing and must include a reason to support the amendment. Your request may be denied if we believe that the information is complete and accurate, if the information is not part of the medical information that you would be permitted to inspect or copy, or if we did not create the information.

Accounting of Disclosures: You may request a list of disclosures that we have made of your medical information over the previous six (6) years. You may not request an accounting for dates of service prior to April 14, 2003. Your first request within a 12-month period is free, but we may charge for additional lists within the same 12-month period.

Paper Copy of This Notice: You are entitled to receive a paper copy of our Notice of Privacy Practices by using the contact information supplied on the first page.

Filing a complaint: If you believe that we have violated your privacy rights, you may file a complaint directly with us using the contact information on the first page. You may also file a complaint with the Secretary of the Department of Health and Human Services. You will not be penalized for complaining.

Provide an Authorization for Other Uses and Disclosures: We will request your written authorization for uses and disclosures of your medical information that are not identified in this notice or permitted by law. You may revoke your authorization at any time in writing.