North Texas Digital Imaging Patient Information

HOW DID YOU FIND OUR CLINIC?

(CIRCLE ONE.) **DR. FRIEND EX-PATIENT INTERNET SIGN OTHER**_____

LAST NAME_____FIRST NAME_____MI_____

ADDRESS_____CITY_____ST_____ZIP_____

HM #_____WK#_____CELL#_____

SS#_____D.O.B._____MARITIAL STATUS_____

EMAIL ADDRESS_____

REFERRING PHYSICIAN_____PHONE #_____

EMPLOYER_____ OCCUPATION_____

TELEPHONE #_____

ADDRESS_____CITY_____ST _____ZIP_____

IF AN INJURY, DATE OF INJURY_____ADJUSTOR _____

ADJUSTOR'S PHONE _____

INSURANCE INFORMATION

INSURANCE COMPANY_____PHONE #_____

INSURER'S NAME _____DOB_____

EMERGENCY CONTACT_____PHONE#_____

FINANCIAL RESPONSIBILITY

It is customary to pay for professional services at the time the service is rendered. Patients with private health insurance must remember that they are responsible for the amount their insurance company does not cover at the time of services. Should your insurance reject your claim, you are responsible for the full amount.

I AM ACCEPTING FINANCIAL RESPONSIBILTY FOR ALL MEDICAL BILLS.

I authorize payment of medical benefits due me out of any indemnity under the terms of my insurance policy to be directly paid to North Texas Digital Imaging upon receipt of an itemized billing from the same. I authorized payment of any medical bills by attorney or any automobile insurance.

_____

SIGNATURE OF PATIENT DATE

_____

SIGNATURE OF RESPONSIBLE PARTY DATE

North Texas Digital Imaging

AUTHORIZATION FOR RELEASE OF INFORMATION

Date_____

I, _____, hereby request and authorize
(Patient)
North Texas Digital Imaging to release to

□ Physician _____

□ Insurance Company _____

□ Attorney _____

□ Employer_____ _____

□ Other (Family Member)_____

medical information and/or copies of my medical records pertaining to physical therapy.

I understand that:

1. Such information will be released only with due safeguards against abuse and misuse of the information or authorization.
2. This authorization does not authorize release of information by NTDI to any other organization or agency unless I grant further authorization.
3. This authorization shall continue in effect for one year until all insurance payments are final.

_____ _____
Patient's Signature Signature of agent or responsible party for minor or incompetent patient

_____ _____
Witness Relationship to patient

North Texas
Digital Imaging

Consent for Purposes of Treatment, Payment and Health Care Operations

I consent to the use or disclosure of my protected health information by **North Texas Digital Imaging Center** for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of **North Texas Digital Imaging Center**.

I understand that diagnosis or treatment of me by my physician may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. **North Texas Digital Imaging Center** is not required to agree to the restrictions that I may request. However, if **North Texas Digital Imaging Center** agrees to a restriction that I request, the restriction is binding on **North Texas Digital Imaging Center** and my physician.

I have the right to revoke this consent, in writing, at anytime, except to the extent that my physician or **North Texas Digital Imaging Center** has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created on received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review North **Texas Digital Imaging Center's** Notice of Privacy Practices prior to signing this document.

North Texas Digital Imaging Center's Notice of Privacy Practices has been provided and/or offered to me.

The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of **North Texas Digital Imaging Center**.

This Notice of Privacy Practice also describes my right and the duties of my physician with respect to my protected health information.

North Texas Digital Imaging Center reserves the right to change the privacy practices that are described in the Notice of Privacy Practices.

I may obtain a revise notice of privacy practices by calling **North Texas Digital Imaging Center** at 972-681-4000 and request a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient or Personal Representative

Name of Patient or Personal Representative

Date

Description of Personal Representative's Authority

Printed Name of My Physician_____

North Texas Digital Imaging

Grievance Procedures/Patient Rights

Procedure for Grievance

1. A grievance must be in writing and contain the name and contact information of the person filing it. It must briefly describe the alleged incident.
2. The grievance must be received by the office manager within 14 business days of the alleged occurrence.
3. The office manager or his/her designee will investigate the matter as may be appropriate to determine its validity.
4. The office manager or designee will respond to the complaint within 7 business days.
5. If the grievance cannot be resolved at this point, the grievant will be provided the name and address of the Texas Department of Health licensing branch for Imaging Services.

Patient Rights

All patients have a right to proper and humane treatment at all times.

No person should be denied impartial access to diagnostic examinations which are determined medically necessary by their physician.

Caregivers should respect the privacy of all patients.

A patient has the right to communicate with those responsible for his or her care. When language barriers arise an interpreter should be provided.

The patient can address any concerns related to their care to the Clinic's Administrator.

I have received a copy of this form.

Name: _____ Date: _____