RADIOLOGY
IMAGING ASSOCIATES PC
ENDOVASCULAR

Patient Registration Form

Please print all information.
Please correct label if applicable.

Date ________________________

PATIENT INFORMATION

PATIENT NAME ______________________ DOB ______________ ☐ FEMALE ☐ MALE

MAILING ADDRESS ______________________ SS# ______________________

CITY ______________________ STATE ______________ ZIP ______________

PATIENT STATUS ☐ is a minor ☐ has a guardian ☐ has a spouse signing for patient

If checked above, GUARDIAN/SPOUSE NAME ______________________

PHARMACY NAME ______________ ADDRESS ______________________ PHONE ______________

WHAT IS YOUR PREFERRED LANGUAGE?

☐ English ☐ French ☐ Japanese ☐ Korean ☐ Mandarin ☐ Portuguese ☐ Russian
☐ Spanish ☐ Vietnamese ☐ Other ______________

WHAT IS YOUR RACE? (Please choose one.)

☐ Caucasian (white) ☐ Hispanic or Latino ☐ Black or African-American ☐ Asian ☐ American Indian or Alaska Native
☐ Native Hawaiian or Other Pacific Islander ☐ Multi-Racial ☐ I choose not to specify.

COMMUNICATION BETWEEN OFFICE AND PATIENT

You authorize Radiology Imaging Associates, PC, or Invision Sally Jobe to use your information to contact you via telephone for appointment reminders, billing-related inquiries, treatment options or alternatives, or health-related benefits regarding your care at RIA Endovascular or Invision Sally Jobe.

HOME ______________ CELL ______________ WORK ______________ EMAIL ______________

Please provide at least one way to contact you.

*** WOMEN ***

ARE YOU PREGNANT OR IS THERE ANY REASON TO BELIEVE THAT YOU MIGHT BE PREGNANT? ☐ **YES** ☐ **NO**

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY ______________________ POLICY HOLDER'S NAME ______________________

RELATIONSHIP TO POLICY HOLDER ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ______________________

INSURED'S EMPLOYER ______________________ INSURED'S DOB ______________________

GROUP/PLAN # ______________________ POLICY/ID # ______________________

SECONDARY INSURANCE COMPANY ______________________ POLICY HOLDER'S NAME ______________________

RELATIONSHIP TO POLICY HOLDER ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ______________________

INSURED'S EMPLOYER ______________________ INSURED'S DOB ______________________

GROUP/PLAN # ______________________ POLICY/ID # ______________________

COPAY DUE AT TIME OF SERVICES $ ______________________

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YOUR PHYSICIANS

Please list doctors who should receive information on your visit today.

Check Which Doctor(s) Referred You	Type of Doctor	Physician Name	Physician Phone Number
☐	**Primary Care Provider (PCP) — Required** *Primary Care, Family Practice, Internal Medicine*	______	______
☐	Hematologist/Oncologist	______	______
☐	Radiation Oncologist	______	______
☐	OB/GYN	______	______
☐	Vascular Surgeon	______	______
☐	Dermatologist	______	______
☐	Pulmonologist	______	______
☐	Cardiologist/Cardiovascular Surgeon	______	______
☐	Endocrinologist	______	______
☐	Gastroenterologist	______	______
☐	Geriatric Medicine	______	______
☐	Infectious Diseases	______	______
☐	Nephrologist	______	______
☐	Opththalmologist	______	______
☐	Orthopedic Surgeon	______	______
☐	ENT/Otorhinolaryngologist	______	______
☐	Rheumatologist	______	______
☐	Urologist	______	______
☐	Wound Specialist	______	______

My signature confirms I have listed all referring physicians. I give RIA Endovascular permission to contact the physicians listed regarding my medical care.

Signature ______________________________ Date ______________

HOW DID YOU HEAR ABOUT US?

Check as many as apply.

☐ Physician ☐ Ad ☐ Article ☐ Brochure ☐ Event ☐ Friend ☐ Google ☐ Health Club
☐ www.riaendovascular.com ☐ Letter ☐ Magazine ☐ Radio ☐ Social Media ☐ Store ☐ Television ☐ Other

List specifically. ______________________________

PATIENT CONSENT

I, the undersigned do hereby (1) consent to the performance of medical services, (2) authorize payment to be made directly to RIA Endovascular, and (3) authorize RIA Endovascular to disclose for the purpose of reimbursement or quality assurance, information from the patient's medical/surgical records to his/her insurance company, or corporation or to any government agency.

I am aware that if **NO** insurance information is provided or the above insurance information is not complete or accurate, I am financially responsible for all services rendered. I understand that RIA Endovascular will collect directly from me any co-insurance deductibles and/or co-payments due in accordance with my health care coverage/plan.

Signature ______________________________ Date ______________

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Medical History & Review of Systems

Please provide us with your medical history.

Date ______________________

Review of Systems

General
- ☐ Abnormal weight loss
- ☐ Abnormal weight gain
- ☐ Fatigue
- ☐ Weakness
- ☐ Chills
- ☐ Other
- ☐ **NONE**

Skin
- ☐ Rash
- ☐ Itching
- ☐ Other
- ☐ **NONE**

Ear/Nose/Throat
- ☐ Trouble swallowing
- ☐ Sore throat
- ☐ Hearing loss
- ☐ Ringing
- ☐ Nose bleeds
- ☐ Other
- ☐ **NONE**

Eyes
- ☐ Visual disturbances
- ☐ Wear glasses
- ☐ Contacts
- ☐ Double/blurry vision
- ☐ Other
- ☐ **NONE**

Cardiovascular
- ☐ Chest pain
  - ☐ While breathing
  - ☐ Throat pain
  - ☐ Pain over heart
  - ☐ Pain near ribs
- ☐ Palpitations
- ☐ Syncope (fainting)
- ☐ Other
- ☐ **NONE**

Respiratory
- ☐ Cough
- ☐ Wheeze
- ☐ Shortness of breath
- ☐ Fever
- ☐ Other
- ☐ **NONE**

Hematologic
- ☐ Easy bruising
- ☐ Other
- ☐ **NONE**

Gastrointestinal
- ☐ Heartburn
- ☐ Reflux
- ☐ Indigestion
- ☐ Constipation
- ☐ Diarrhea
- ☐ Other
- ☐ **NONE**

Musculoskeletal
- ☐ Aching
- ☐ Swelling
- ☐ Other
- ☐ **NONE**

Endocrine
- ☐ Hot flashes
- ☐ Coarse hair
- ☐ Hair loss
- ☐ Other
- ☐ **NONE**

Neurological
- ☐ Headache
- ☐ Memory loss
- ☐ Dizziness
- ☐ Numbness
- ☐ Tingling
- ☐ Balance problems
- ☐ Falls
- ☐ Other
- ☐ **NONE**

Allergies
- ☐ Seasonal hay fever
- ☐ Foods
- ☐ Medications
- ☐ Other
- ☐ **NONE**

Urinary
- ☐ Urgency
- ☐ Frequency
- ☐ Difficulty urinating
- ☐ Other
- ☐ **NONE**

Women Only
- ☐ Heavy menstrual bleeding
- ☐ Bleeding between cycles
- ☐ Other
- ☐ **NONE**

Medical History

Cardiac
- ☐ Heart attack
  Date ______________
- ☐ Congestive heart failure
- ☐ Heart murmur
- ☐ Fluid around heart
- ☐ Pacemaker
- ☐ High blood pressure
- ☐ Other
- ☐ **NONE**

Respiratory
- ☐ Pneumonia
- ☐ COPD/Emphysema
- ☐ Asthma
- ☐ Bronchitis
- ☐ Reactive airway
- ☐ TB
- ☐ Fluid around lungs
- ☐ Blood clots in lungs
- ☐ Dyspnea
- ☐ Other
- ☐ **NONE**

Neurological
- ☐ Headaches/Migraines
- ☐ CVA/Stroke/TIA
  Date ______________
- ☐ Seizures
- ☐ Closed head injury/Trauma
- ☐ Dementia
- ☐ Alzheimer's
- ☐ Meningitis
- ☐ Aneurysm
- ☐ Parkinson's
- ☐ Multiple Sclerosis
- ☐ Other
- ☐ **NONE**

Eyes
- ☐ Left ☐ Right ☐ Both
- ☐ Vision problems
- ☐ Problems with retina
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Other
- ☐ **NONE**

Ears/Nose/Throat
- ☐ Hearing impairment
  - ☐ Left ☐ Right ☐ Both
- ☐ Frequent sinusitis
- ☐ Other
- ☐ **NONE**

Circulatory/Hem/Lymph
- ☐ Left ☐ Right ☐ Both
- ☐ Peripheral vascular disease
- ☐ Claudication - Leg cramps with walking
- ☐ Blood clots in legs
- ☐ Blood clotting disorder (genetic)
- ☐ Other
- ☐ **NONE**

Endocrine
- ☐ Thyroid
- ☐ Diabetes Type I/II
  - ☐ Oral ☐ Insulin
- ☐ Other
- ☐ **NONE**

Musculoskeletal
- ☐ Arthritis
  What type ____________
  Where ____________
- ☐ Fractures/Trauma
  What type ____________
  Where ____________
- ☐ Osteoporosis
- ☐ Gout
- ☐ Other
- ☐ **NONE**

Gastrointestinal
- ☐ Ulcers
- ☐ Colitis
- ☐ Crohn's Disease
- ☐ GI bleeding
- ☐ Pancreatitis
- ☐ Hiatal Hernia
- ☐ Diverticulitis
- ☐ GERD
- ☐ Other
- ☐ **NONE**

☐ **Cancer**
Type ________________
- ☐ Current Treatment
- ☐ Other
- ☐ **NONE**

Infectious Disease
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ HIV/AIDS
- ☐ MRSA
- ☐ Other
- ☐ **NONE**

Gynecological
- ☐ Sexually transmitted disease
- ☐ Abn Pap Smear
- ☐ Endometriosis
- ☐ Other
- ☐ **NONE**

Genitourinary
- ☐ Prostate problem
- ☐ Kidney disease
- ☐ Dialysis
- ☐ Frequent urinary tract infections
- ☐ Kidney stone
- ☐ Acute Renal Failure
- ☐ Other
- ☐ **NONE**

Skin Disorders
- ☐ Eczema
- ☐ Rashes
- ☐ Herpes/Shingles
- ☐ Skin Cancer
- ☐ Other
- ☐ **NONE**

Psychosocial
- ☐ Mental health problem
- ☐ Depression
- ☐ Anxiety
- ☐ Addiction
- ☐ Other
- ☐ **NONE**

Pain
- ☐ Acute
- ☐ Chronic
- ☐ Treatment
- ☐ Pain Scale 1-10 ____
- ☐ Other
- ☐ **NONE**

Women Only
- ☐ # Pregnancies ____
- ☐ # Live births ____
- ☐ Other
- ☐ **NONE**

Fill out completely.

Surgical History ☐ **NONE** ____

____

Social History

Marital Status ______________ Job/Career ______________

Marijuana ☐ None ☐ Past ☐ Present # of Years Smoked ________ # of Joints Per Day ________

Tobacco ☐ None ☐ Past ☐ Present # of Years Smoked ________ # of Packs Per Day ________

Alcohol Use Per Week ______________ Illicit Drugs ______________

Family History of Medical Conditions

Mother ______________ ☐ Deceased Father ______________ ☐ Deceased

Brother ______________ ☐ Deceased Brother ______________ ☐ Deceased

Sister ______________ ☐ Deceased Sister ______________ ☐ Deceased

Grandparents ______________ ______________

Patient Signature ________________________________ Date ______________

Provider Signature ________________________________ Date ______________

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Patient Medication Record

Allergies? ____

☐ None ☐ Latex ☐ Contrast ☐ Iodine ☐ Betadine

Pharmacy ______________________________ Pharmacy Phone No. ____________________

Today's Date	Medication Dosage/Strength/Frequency/Route	Change D/C Date

Date of **Visit**	**Initials of person reviewing meds**	**Where there any changes? Y/N**	**Date of Visit**	**Initials of person reviewing meds**	**Where there any changes? Y/N**

Patient Signature ______________________________ Date ____________

Provider Signature ______________________________ Date ____________

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MEDICAL INFORMATION AUTHORIZATION RELEASE - HIPAA

In general, the Health Information Portability and Accountability Act (HIPAA) privacy rule gives individuals the right to request restrictions on the use and disclosure of their protected health information (PHI). The individual is also provided the right to request confidential communication or that communication of PHI is made by alternative means (such as sending correspondence to the individual's office instead of the individual's home). We will take reasonable steps to limit the use or disclosure of and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual. We will keep a record of all PHI disclosures. Uses and disclosures may be permitted without prior consent in the event of an emergency.

I authorize the staff of RIA Endovascular to release any medical information to the following people:

Spouse ______________________________ Phone ______________

Partner ______________________________ Phone ______________

Parent or Guardian ______________________________ Phone ______________

Other ______________________ Relationship ______________ Phone ______________

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION AND PHOTOGRAPHY

I hereby give my consent to have before- and after-surgery photographs, made of myself and agree that these images may be used by RIA Endovascular. **My name and face will NOT be included under any circumstances.** Only references to the sex, age, condition and other life-style limiting factors relevant to the treated condition will be listed. Non-identifying information may appear in professional and education presentations, on the website, and in any media formats, including composite or modified representations for such purposes. This includes digital, printed materials, public relations, advertising, trade, and other commercial purposes by RIA Endovascular.

I further release RIA Endovascular from any claims that may arise regarding the use of my image(s) including any claims of defamation, invasion of privacy, or infringement of moral rights, rights of publicity or copyright. I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked in writing, this authorization will remain in effect in perpetuity. RIA Endovascular, the facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

____
☐ Signature of Patient / ☐ Patient's Legal Representative (Please check one.)

____
Signature of Witness

____
Name of Patient (Please print.)

____
Name of Witness (Please print.)

____
Date

____
Date

RIA ENDOVASCULAR TEAM APPROACH

RIA Endovascular offers a team approach to your treatment. Our five board-certified, fellowship-trained interventional radiologists and two specialized nurse practitioners provide care in our office and in hospitals around the region. They work closely with our nurses, vascular sonographers, medical assistants, pre-certification insurance specialists and other support staff.

Together, our goal is to provide patient-focused, high-quality care. We truly appreciate your trust in RIA Endovascular.

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 IT CAREFULLY.

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<u>How we may use and disclose health information about you:</u>

We may use and disclose medical information about you for **treatment** (by sending information about your procedure to another physician involved in your care as part of a referral): to **obtain payment for your treatment** (such as sending information to your insurance company or Medicare) and to **support our health care operations** (such as comparing patient data to improve our quality of care).

We may disclose medical information about you to our business associates that provide us with administrative support in rendering your care. Business associates are required by contract and by law to comply with the same provisions of federal privacy laws (HIPAA).

We may also use or disclose your medical information for several other purposes. Subject to certain requirements, we may give out medical information about you for public health purposes, abuse or neglect reporting, health oversight audits or inspections, research studies, workers compensation purposes and emergencies. We also will disclose medical information when required to by law, such as in response to a request from law enforcement in specific circumstances, or in response to valid judicial or administrative orders.

We also may contact you for appointment reminders, or to tell you about or recommend possible treatment options, alternatives, health related benefits or services that may be of use to you.

We will request your written authorization before using or disclosing medical information about you for marketing purposes, for uses and disclosures that constitute the sale of health information and for other uses and disclosures that are not described in this notice. If you authorize certain uses or disclosures of your health information, you can later revoke that authorization by notifying us in writing of your decision.

<u>Your rights regarding your medical information:</u>

You have the right to review and obtain a copy of your medical record.

You have the right to restrict disclosures of your protected health information to health plans, relative to specific services, if you have paid for that service out of pocket in full, unless the disclosure is required by law.

You have the right to request that we amend your medical record by submitting a request in writing that provides your reason for requesting the amendment.

You have a right to a list of any instance since April 14, 2003, where we have disclosed your medical information, other than for treatment, payment, health care operations or per your written request.

You have the right to request how your medical information is communicated to you. Your request must specify how or where you wish to be contacted; all reasonable requests will be honored.

You have the right to be provided with a paper copy of this notice for your own use if you so request.

<u>Our responsibility to you:</u>

- We have a duty to maintain the privacy of your medical information and provide you with the notice of our legal duties and practices.
- We are required by law to notify you following a breach of your unsecured protected health information.
- We are responsible for abiding by the terms of the privacy notice currently in effect.
- We are responsible for providing our patients with revisions to this privacy notice by ensuring the most current notice is always posted on our web site. We reserve the right to change the terms of this notice without advance notice, making it effective for all protected health information we maintain. We are responsible for maintaining documentation of privacy notices and written acknowledgements for a period of six years from the date of creation or the date last in effect, whichever is later.

<u>Complaints:</u>

If you are concerned that your privacy rights may have been violated, or if you disagree with a decision we made about access to your records, you may contact the Privacy Officer at (720) 493-3731.

You may also file a complaint with the Department of Health and Human Services' Office of Civil Rights at (800) 368-1019.

If you have a complaint about Radiology Imaging Associates, PC, the provider of professional imaging interpretation for Invision Sally Jobe, you may file a complaint with the Joint Commission at (800) 994-6610.

Signature ____ Date ____________________

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Patient Payment Policy
Your Financial Responsibility

We are pleased that you came to the RIA Endovascular for your treatment! It is the goal of our entire staff and medical team to provide you with the best outcome possible.

How may I pay?	We accept cash, personal checks and credit cards (VISA, MasterCard, American Express and Discover).
Do I need a referral?	If you are insured through an HMO, you are required to obtain an authorization form from your primary care provider, family physician or nurse practitioner before your visit(s) can be scheduled. Although we will make every effort to help you with this process, ***if we have not received an authorization from your referring physician prior to your arrival at the office, you may elect to self-pay or have your visit rescheduled.***
What is my financial responsibility for services?	This will vary depending on such factors as your insurance coverage, healthcare needs and financial considerations. ***See the grid below for more details.***

Your Insurance Coverage	Your Payment Responsibilities Include:	I have read and understand this form and my financial responsibility. *Please initial.*
Self-Pay No Insurance	All payment is expected in full at the time of service unless you have previously arranged a payment plan with us. *Self-Pay payment plans must be made prior to your visit by calling RIA Endovascular at 720.493.3406.*	
Self-Pay Individual has active insurance but voluntarily elects not to use it	All payment is expected in full at the time of service unless you have previously arranged a payment schedule with us. **NOTE: Once you elect to self-pay for a service, you remain responsible for 100-percent of the payment due to RIA Endovascular even if you later decide to submit a claim for services to your insurance carrier.** *Self-Pay payment plan must be made prior to your visit by calling RIA Endovascular at 720.493.3406.*	
Commercial Insurance *In-Network or Out-of-Network*	All payment is expected in full at the time of service for all known and estimated co-pays and deductibles. After service is provided, you will be responsible for any part of your bill not paid by your insurance carrier, including co-pays, deductibles, co-insurance. This includes the balance between the initial known and estimated out-of-pocket costs and the actual patient responsibility cost as determined by your insurance carrier.	
Medicaid	If for any reason your service is not covered due to a cancellation, break in coverage or non-coverage by Medicaid, you will be responsible for all charges related to the services received.	
Medicare	We will file all claims to Medicare and any secondary insurance/s. It is your responsibility to provide our office with any supplemental insurance information. You will receive a statement for any charges not covered by Medicare and secondary insurance carrier/s.	

Late and No-Show Policy

If you show up 15 minutes or more past your scheduled appointment time, you are considered late and we may need to reschedule your appointment. If you can't make an appointment, please let us know so we can give your appointment to another patient. We reserve the right to apply a no-show fee of $75 where allowable by law for no-show appointments.

Acknowledgment

- **I have read, understand and agree to the above Patient Payment Policy. I understand that charges not covered by my insurance company, as well as applicable co-payments and deductible, are my responsibility.**
- **I authorize my insurance benefits to be paid to RIA Endovascular.**
- **I authorize RIA Endovascular to release pertinent medical information to my insurance company when requested and to facilitate payment of a claim.**

Patient Signature ______________________ Date ____________

DISCLOSURE OF PHYSICIAN OWNERSHIP

8200 E Belleview Ave, Suite 600E
Greenwood Village, CO 80111
PH: 720.493.3406 FAX: 303.643.4510

Dear Patient,

The staff and physician owners of RIA Endovascular welcome you to our facility. To ensure that we are providing the best possible patient experience, we encourage you and your family members to let us know how we are doing and if you have questions any time during your care.

Throughout the course of your treatment with RIA Endovascular you may be referred for outpatient diagnostic imaging or interventional radiology procedures in our procedure room. It is our intent and responsibility to inform you that our physicians have a financial relationship with the RIA Interventional Suite and the outpatient imaging facilities Invision Sally Jobe.

You have the option as a patient to choose where you want your diagnostic imaging or interventional radiology procedures performed. We will work with you to obtain authorization from your insurance at the facility of your choice. If you do not inform us during your visit of alternative facilities for your diagnostic imaging or interventional radiology procedures, we may send a referral to RIA Interventional Suite and/or Invision Sally Jobe. We are always available to discuss your options and answer any questions that you may have. In addition, your insurance company can be used as a resource for alternative facility options.

Sincerely,
The Physicians at RIA Endovascular

____ __________________

Patient or Legal Guardian Signature Date