PATIENT NAME: _____ MRN: _____

TODAY'S DATE: _____

EXAM/CLINICAL INDICATION: _____

_____

OFFICE USE ABOVE THIS LINE

VISIT INFORMATION

WORK RELATED INJURY:	□ YES	□ NO	DATE:	EMPLOYER CONTACT NAME:
AUTO ACCIDENT:	□ YES	□ NO	DATE:	
OTHER ACCIDENT/INJURY:	□ YES	□ NO	DATE:	
PREGNANT:	□ YES	□ NO	□ UNSURE	DATE OF LAST MENSTRUAL PERIOD:

PATIENT INFORMATION

NAME (FML):	DOB:	WEIGHT	GENDER
SSN:	AGE:		MARITAL STATUS: S M W D O
ADDRESS: CITY, STATE, & ZIP:			
PRIMARY #:	WORK #:		SECONDARY#:
EMPLOYER: EMPLOYER ADDRESS:			
ARE YOU A RESIDENT IN A NURSING HOME: ☐ No ☐ Yes (IF YES, PLEASE PROVIDE NAME OF FACILITY)			

PATIENT PORTAL ACCESS ** PLEASE READ **

In order to provide our patients with electronic access to their Clinical Care Record, an email address is required as the unique Username. A summary of your visits, medications, allergies, etc. is available for review.

Please indicate by circling whether or not this is requested or declined.

REQUESTED	EMAIL:
DECLINED	Please initial

PRIMARY INSURANCE **SECONDARY INSURANCE**

POLICY HOLDER NAME:	POLICY HOLDER NAME:
POLICY HOLDER DOB: GENDER: **M** **F**	POLICY HOLDER DOB: GENDER**: M** **F**
PATIENT RELATIONSHIP TO THE POLICY HOLDER:	PATIENT RELATIONSHIP TO THE POLICY HOLDER:
POLICY NAME:	POLICY NAME:
POLICY NUMBER:	POLICY NUMBER:

PATIENT NAME: _____ MRN: _____

TODAY'S DATE: _____

GUARANTOR INFORMATION (IF PATIENT IS A MINOR)

NAME:	
ADDRESS:	
PHONE:	
RELATIONSHIP TO PATIENT:	
SSN:	DOB:

Expires 365 days

******* For today's visit only******* I certify that I have a legal right to **Radiology Consultants of Lynchburg, Inc., Central Virginia Imaging, LLC, or Va. Vein Specialists'** information and that I am either the patient or legal guardian of the patient to whom these records apply.

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. I may see and obtain a copy of the information described on this form, for a reasonable copy fee, by requesting it in writing. Under **Virginia** law this information will be provided to me within 15 days of my request.
3. I may revoke this authorization at any time by notifying **Radiology Consultants of Lynchburg Inc. and Central Va. Imaging LLC's** Privacy Officer, in writing, of my intent to do so. This will not affect any actions taken prior to receiving the revocation.
4. If the requester or receiver is not a health plan, health care clearing house, or health care provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed.
5. I acknowledge that I have the right to a copy of this authorization after I have signed it.
6. I understand that this authorization gives permission to mail medical records to the address listed on the front of this form.

☐ Check here if you **decline** the above authorizations and you do NOT wish for your protected health information to be mailed.

I authorize the release of my PHI (Protected Health Information) to be released to the following persons:

List person FULL NAME (other than patient) that PHI is to be released to:	***Relationship***	***Date of Birth***

*****FOR AUTHORIZED PERSON LISTED ABOVE- Photo ID required at pick-up*****

I authorize release of pertinent medical information to my insurance in order to process my claim.

1. I authorize my insurance benefits to be paid directly to Radiology Consultants of Lynchburg and (or) Central Virginia Imaging.
2. If my insurance fails to pay this balance, or if I do not have insurance coverage, I understand that I am financially responsible for this service.
3. I acknowledge a Notice of Privacy Practices has been provided.
4. **I understand that any payments made today have been based on an estimated amount.** I may receive a bill for additional balances following the processing of my claim.

PATIENT/PARENT/LEGALGUARDIAN SIGNATURE: _____ Date: _____