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:

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. (Excludes itemized billing statements.)

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*****

1. I authorize release of pertinent medical information to my insurance in order to process my claim.
2. I authorize my insurance benefits to be paid directly to Radiology Consultants of Lynchburg and (or) Central Virginia Imaging.
3. 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.
4. I acknowledge a Notice of Privacy Practices has been provided.
5. *(Initial Please)* _____ I understand that any figure/quote given, or payments made today have been based on an estimated amount. There are a lot of contributing factors to giving an estimate. I understand that I may receive a bill for additional balances following the processing of my claim greater than the quote/estimate given at the time of service.
6. *(Initial Please)* _____ **In the event that I contract the COVID-19 virus, I authorize the Virginia Department of Health (or your state of record) to share my information with Radiology Consultants of Lynchburg and Central Virginia Imaging so that they can appropriately quarantine only the staff that I specifically come in contact with. I also understand that I can contact Radiology Consultants on my own to notify them.**

PATIENT/PARENT/LEGALGUARDIAN SIGNATURE: _____ Date: _____