Iowa Radiology- 2020

Due to changes in the United States Health Care Reform, we are now required to obtain additional information at the time of service.

PATIENT INFORMATION

Patient Name: _____Date of Birth: _____
Last First MI

Soc. Sec. #: _____ Sex: M_____ F_____ Marital Status:_____

Please circle one:

Caucasian Asian African American American Indian Decline

Address: _____
Street/Apt # City State Zip

E-Mail Address: _____
If you give us your e-mail address, we will use it to communicate and confirm appointments.

Home Phone: _____ Work Phone: _____ Cell Phone: _____

PHYSICIAN INFORMATION

Referring: 1. _____ 2._____

Have you had prior radiology services under a previous last name? If yes please list: **_____**

Emergency Contact Information:

Name: _____Rel: _____ Phone #: _____

If Patient is a minor, please designate guarantor/responsible party information:

Name: _____ Rel: _____ Date of Birth: _____

PLEASE SELECT ONE OF THE FOLLOWING:

***Insurance policy is held by:**

Self/Patient*_____ Spouse*_____ Parent*_____ other*_____ No ins. / Self Pay*_____

*** If insured is someone other than self/patient, please complete the following:**

Primary INS: Name of insured person/employee: _____Insured's DOB: _____

Secondary INS: Name of insured person/employee: _____Insured's DOB: _____

Release of Records and Authorization of Insurance Benefits

I give Iowa Radiology the consent to treat me as a patient in this facility. I hereby authorize any medical facility to release my previous mammograms, films/images and reports to Iowa Radiology for comparative purposes. In addition, I authorize Iowa Radiology to release my mammograms, films/images and reports to any other facility for comparative purposes.

I give permission to release information requested by the insurance company to pay this claim. I hereby authorize payment directly to Iowa Radiology for all services provided. In making this authorization, I understand that I will be held responsible for any unpaid balances not covered by my insurance company. I assume and agree to be responsible for an administrative fee if my account enters a default status and is considered "past due".

I am aware that Iowa Radiology is participating in the clinical education of students attending Iowa Health Des Moines School of Radiologic Technology; I consent to the receipt of services from students in the program. (Students will not be participating in clinical training in mammography or ultrasound).

**This authorization is good for one calendar year from the date signed below.

_____/_____/2020

Patient (or legal guardian) **Signature** **Date**

_____

Relationship (if not patient) Parent or legal guardian's date of birth

Mammogram Patients Only

If you need further work up following your screening mammogram, such as additional views or ultrasounds, we will contact you to schedule an appointment at our Diagnostic Center at 12368 Stratford Drive, Clive, Iowa.

COVID 19 Questionnaire

In the last 14 days have you traveled outside of the US?

Yes **No**

Do you have new or worsening onset of any of the following symptoms: fever, cough, shortness of breath, runny nose, sore throat, chills, headache, loss of taste /smell, eye drainage, or congestion?

Yes **No**

Within the last 14 days, have you been exposed to someone positive for COVID-19 or who has symptoms compatible with COVID-19 who has not yet received a negative test result?

Yes **No**

Signed: _____ Date: _____