

Patient Profile

Registered Location: Mink Radiologic Imaging

Social Security Number: _____

First Name: _____

Last Name: _____

Address 1: _____

Address 2: _____

City: _____

State: _____

Zip Code: _____

Home Phone: _____

Work Phone: _____

Mobile Phone: _____

Email: _____

Date of Birth: _____

Gender: Male Female

Insurance

Primary Insurance Carrier Name: _____

Policy Number: _____

Group Name: _____

Group Number: _____

Pre-Certification Phone Number: _____

Secondary Insurance

Secondary Insurance Carrier Name: _____

Policy Number: _____

Group Name: _____

Group Number: _____

Relationship To Insured

Relationship: _____

First Name / Last Name: _____

Date of Birth: _____

Gender: Male Female

I acknowledge that to the best of my knowledge, this information is current and correct.

Signature: _____

Date: _____

Consent and Conditions of Outpatient Services

CONSENT TO MEDICAL AND SURGICAL PROCEDURES: The undersigned consents to the diagnostic exams or procedures which may be performed during this visit which may include but are not limited to x-ray examinations, medical procedures, or services rendered the patient under general and special instructions of the patient's physician.

RELEASE OF INFORMATION: The center will obtain the patient's consent and his/her written authorization to release information, other than basic information, concerning the patient, except in those circumstances when the center is permitted or required by law to release information.

The undersigned agrees that, to the extent necessary to determine liability for payment and to obtain reimbursement, the center may disclose portions of the patient's record, including his/her medical records, to any person or corporation which is or may be liable, for all or any portion of the center's charges, including but not limited to insurance companies, health care service plans, or worker's compensation carriers.

I authorize release of the Medical Record to any physician participating in my care.

FINANCIAL AGREEMENT: The undersigned agrees, whether he/she signs as agent or as patient, that in consideration of the services to be rendered to the patient, he/she hereby individually obligates himself/herself to pay the account of the center in accordance with the regular rates and terms of the center. Should the account be referred to an attorney or collection agency for collection, the undersigned shall pay actual attorney's fees and collection expenses. All delinquent accounts shall bear interest at the legal rate.

ASSIGNMENT OF INSURANCE BENEFITS: The undersigned authorizes, whether he/she signs as agent or as a patient, direct payment to the center of any insurance benefits otherwise payable to or on behalf of the patient for these outpatient services, at a rate not to exceed the center's actual charges. It is agreed that payment to the center, pursuant to this authorization, by an insurance company shall discharge said insurance company or any or all obligations under a policy to the extent of such payment. It is understood by the undersigned that he/she is financially responsible for charges not paid pursuant to this assignment.

MEDICARE RELEASE: Patient's Certification, Authorization to Release Information, and Payment Request. I certify that the information given by me in applying for payment under the Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or Intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. The undersigned certifies that he/she has read the foregoing, received a copy thereof, and is the patient, the patient's legal representative, or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

| | | |
|------|--|--------------|
| Date | Signature of Patient/Parent/Legal Guardian | Relationship |
|------|--|--------------|

UPON REQUEST A COPY OF THIS DOCUMENT IS TO BE GIVEN TO THE PATIENT

MINK RADIOLOGIC IMAGING

8670 Wilshire Blvd., Suite 101 - Beverly Hills, CA 90210

13160 Mindanao Way, Suite 175 - Marina del Rey, CA 90232

CONSENT AND CONDITIONS OF OUTPATIENT SERVICES

ABDOMEN/SMALL PARTS ULTRASOUND QUESTIONNAIRE

Name: _____

Procedure: _____

Reason for exam/complaint: _____

How long have you had this problem? _____

Have you had any other tests for this problem? Yes No

If yes, Where? _____ When? _____

If you have, please list a history of your medical conditions:

List your medications:

If you have had any surgeries, please list:

Sign: _____ Date: _____

PELVIC ULTRASOUND QUESTIONNAIRE

Name: _____

Procedure: _____

First day of your Last Menstrual Period: _____

Are you currently using birth control pills? Yes No

Hormone Replacement Therapy: Yes No

If yes,

Sequential: _____ Continuous: _____ Natural: _____ IUD: _____

Tamoxifen or other medications related to breast CA? Yes No

Please describe your symptoms:

Please describe your surgical history:

Have you had any other tests for this problem? Yes No

If yes, Where? _____ When? _____

Please list: No. of children: _____ No. of pregnancies: _____

Are you allergic to latex? Yes No

Sign: _____ Date: _____

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.

Uses and Disclosures:

Treatment: Your health information may be used by our staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of tests and procedures will be available in your medical records to all health professionals who may provide treatment or who may be consulted by our staff members.

Payment: Your health information may be used to seek payment from your health plans, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations: Your health information may be used as necessary to support the day-to-day activities of Mink Radiologic Imaging. For example, information on the services you received may be used to support budgeting and financial reporting and activities to evaluate and promote quality.

Public health reporting: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosure require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

Appointment reminders: Your health information may be used by our staff to send you appointment reminders.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- The right to request instructions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice.

Mink Radiologic Imaging Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

Requests to Inspect Protected Health Information

As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the office manager.

Complaints

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

HIPPA Compliance Department
8670 Wilshire Boulevard, Suite 101
Beverly Hills, CA 90211

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address.

You will not be penalized or otherwise retaliated against for filing a complaint.

Contact Person

The name and address of the person you can contact for further information concerning our privacy practice is:

Bryon Rose
Privacy Office
8670 Wilshire Boulevard, Suite 101
Beverly Hills, CA 90211

Effective Date

This Notice is effective on or after April 14, 2003.

I have received the Notice of Privacy Practices, and I have been provided an opportunity to review it.

Signature

Date