

Patient Registration Form
IF THIS FORM IS NOT COMPLETE, WE CAN NOT BILL YOUR INSURANCE

LEGAL NAME (Please PRINT legibly!!) _____		CCI#: _____ <small>(for office use only)</small>
Patient Name: _____		First Visit? YES NO
Address: _____		City/St/Zip: _____
Home Phone: () _____		Cell: () _____
		Work: () _____
SS#: _____		D.O.B. _____
		Sex: M F
		Marital Status: S M D W
Employer: _____		Address: _____
Occupation: _____		Full Time / Part Time / Student
Emergency Contact: _____		Phone: () _____
Relationship: _____		
Referring Physician: _____		Primary Physician: _____
Who will be responsible for your account? Self / Spouse / Father / Mother / Other _____		
Name: _____		SSN: _____
		Phone: () _____
Address: _____		City/St/Zip: _____
Employer: _____		Phone: () _____
<u>Primary Insurance Information:</u>		<u>Secondary Insurance Information:</u>
Ins Co Name: _____		Ins Co Name: _____
Address: _____		Address: _____
Policy Holder Name: _____		Policy Holder Name: _____
Relationship to Patient: _____		Relationship to Patient: _____
Policy Holder's Employer: _____		Policy Holder's Employer: _____
SSN/ID#: _____		SSN/ID#: _____
Policy/Group#: _____		Policy/Group#: _____
Policy Holder's Birthdate: _____		Policy Holder's Birthdate: _____
Work Related? YES NO		Is an attorney involved? YES NO
Auto Accident? YES NO		Attorney Name: _____
Injury Date: _____		Address: _____
		Phone: () _____
ASSIGNMENT OF BENEFITS: I hereby authorized Cherry Creek Imaging Center to release and/or obtain any information necessary to process insurance claims for services rendered to me or my dependent. I also authorize benefits to be paid directly to Cherry Creek Imaging Center. I understand that I will be responsible for co-pays, deductibles and any balances remaining after insurance has paid.		
Signature: _____		Date: _____

PAYMENT AND BILLING POLICY

TO OUR PATIENTS:

To help answer questions you may have, we have outlined our payment policies below. Please feel free to discuss these with us at any time should you have additional questions.

INSURANCE:

As a courtesy to our patients, we will bill all private companies directly; Blue Cross, Aetna, Pacificare, Cigna, Medicare, Medicaid, and all other commercial insurances. Cherry Creek Imaging Center is a preferred provider for most PPO and HMO plans. Let us know if you have questions regarding a particular plan. **You will need to provide our office with your current insurance card(s).** We cannot wait for payment pending third party litigation settlement (i.e. automobile accidents, attorney liens).

Medicare Patients:

As a policy, we do accept assignment for Medicare accounts. We will bill Medicare for you and payment will be sent directly to us.

PAYMENT POLICY:

Accounts are due and payable within thirty days after your insurance has responded to your claim. Self-pay patients will be asked for a portion of their balance at the time of service. Payment arrangements can be made if necessary on the remaining balance. We accept cash, personal checks and all major credit cards. Past due accounts may be turned over to a collection agency. A \$20.00 charge will be applied for NSF checks returned by your bank.

We understand that financial problems do arise from time to time. Let us know if you need to arrange a payment program that will help resolve your balance in monthly installments. Our Accounts Manager will gladly assist you with these arrangements.

Please remember, although you have an insurance claim pending, you are responsible for you deductible and co-payments. Your cooperation and understanding are appreciated. We would be happy to respond to any questions regarding our payment policy on your account. Please contact us at (303) 355-4674, or call our billing office directly at (303) 468-1395 with your inquiries.

Patient/Guarantor Signature

Date

PLEASE PRINT THE FOLLOWING INFORMATION:

Patient: _____ DOB: ____/____/____ CCI#: _____
(Last Name) (First Name) (Middle Initial/Name) (mm/dd/yyyy) (For office use only)



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CHERRY CREEK IMAGING CENTER

CONSENT FOR USE AND DISCLOSURE OF PRIVATE HEALTHCARE

INFORMATION FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

PATIENT: _____ DOB: ____/____/____

SSN: _____ Other Name: _____ CCI#: _____

My health information is a private matter. Cherry Creek Imaging Center has a form that can tell me how Cherry Creek Imaging Center handles my health information. This form is called "Notice of Privacy Practices". If I ask, Cherry Creek Imaging Center will be happy to provide me with the most current "Notice" before I sign this consent. Cherry Creek Imaging Center may update this "Notice" at any time. If I ask, I may obtain a copy of the most current "Notice".

I agree that Cherry Creek Imaging Center may use and disclose my health information to help treat me. I agree that Cherry Creek Imaging Center may use and disclose my information for billing and payment. I also agree to uses and disclosures of my health information to take care of other health care operations. In general, no other uses or disclosure of my health information will occur unless I tell Cherry Creek Imaging Center it's okay to do so. Sometimes the law may allow the release of information without my permission. These situations are unusual. One example would be if a patient threatened to hurt someone.

I may cancel this consent at any time, by doing one of the following:

- Signing and dating a revocation form. I may get this form from Cherry Creek Imaging Center; or
- Writing, signing, and dating a letter to Cherry Creek Imaging Center. The letter must say I cancel my consent to authorize the use and disclosure of my health information for treatment, payment and health care operations.

If I cancel this consent:

- It will be effective except for actions already taken based upon the consent and
- Cherry Creek Imaging Center will not have to provide any more health care services to me.

I have been given the chance to read a current copy of Cherry Creek Imaging Center's "Notice of Privacy Practices". I agree to allow Cherry Creek Imaging Center to use and disclose my health information to carry out treatment, payment and health care operations.

 Patient or legally authorized individual signature

 Date

(FOR CT INTRAVENOUS CONTRAST EXAMS ONLY)

CT SCREENING QUESTIONS

Do you have any of the following conditions or illnesses? (Please circle all that apply)

- Heart Disease
- Asthma
- Respiratory Disease (please specify) _____
- Collagen Vascular Disease (lupus, rheumatoid arthritis, scleroderma, polymyositis)
- Multiple Myeloma
- Kidney Disease or Renal Failure (including tumor and transplant)
- Family History of Kidney Failure
- Diabetes – If Yes, for how long? _____

What medications do you currently take? _____

Are you allergic to any medications or foods (please circle)? YES NO **If YES, please list:** _____

Have you ever received IV contrast for an imaging exam (please circle)? YES NO

If YES, have you ever had a reaction (please circle)? YES NO

FOR INTERNAL USE ONLY

Answers reviewed and verified by: _____

What are your symptoms (i.e. reason for this exam)? _____

How long have you had these symptoms? _____

Previous surgery in this area (please circle)? YES NO **If YES, what type?** _____

Prior imaging tests of this same body part (please circle)? YES NO **If YES, where and when?** _____

Female Patients:

Date of last menstrual period: ___/___/___ Post Menopausal? ___No ___Yes

Are you pregnant or experiencing a later menstrual period? ___No ___Yes

Are you taking oral contraceptives or receiving hormonal treatment? ___No ___Yes

Are you taking any type of fertility medication or having fertility treatments? ___No ___Yes

If yes, please describe: _____

Are you currently breastfeeding? ___No ___Yes

CONSENT FOR CT EXAMINATION

Your physician has requested that we perform a CT scan to aid in the diagnosis of your medical condition. It may be necessary to inject a contrast agent into a vein for improved imaging, depending on the specific test being performed. The contrast material is safe, but a small number of patients may be allergic. **Please inform the technologist if you wish to refuse the contrast.** In most cases the scan can still be performed without the contrast, but with a reduced amount of information for the Physician.

Your signature indicates that you have read and understand the above, and gives your consent for today's CT examination.

Patient/Parent/Legal Guardian Signature _____ Date _____

Witness Signature _____ Date _____

Patient Label