DOCTORS IMAGING | ADVANCED RADIOLOGY. TRUSTED CARE.
4204 TEUTON STREET
METAIRIE, LA 70006

PATIENT INFORMATION FORM

NAME: FIRST _____ **MI** _____ **LAST** _____

SOCIAL SECURITY #: _____ **DATE OF BIRTH:** _____

MAIL ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____

CELL PHONE: _____ **HOME/OTHER PHONE:** _____

HEIGHT _____' _____" **WEIGHT** _____ lbs

RACE: ☐ WHITE ☐ BLACK/AFRICAN AMERICAN ☐ AMERICAN INDIAN/ALASKA NATIVE
☐ ASIAN ☐ NATIVE HAWAIIAN/PACIFIC ISLANDER ☐ OTHER _____

ETHNICITY: ☐ HISPANIC/LATINO ☐ NOT HISPANIC/LATINO

PREFERRED LANGUAGE: _____

SMOKER: ☐ CURRENT EVERYDAY SMOKER ☐ CURRENT SOME DAY SMOKER ☐ FORMER SMOKER
☐ NEVER SMOKER ☐ SMOKER, CURRENT STATUS UNKNOWN ☐ UNKNOWN IF EVER SMOKED

ARE YOU ALLERGIC TO ANY MEDICATION? ☐ YES ☐ NO (If YES, please list the medication & reaction)

_____

_____

MARITAL STATUS (circle answer)**:** MARRIED SINGLE WIDOWED DIVORCED

EMPLOYMENT STATUS (circle answer)**:** FULL-TIME PART-TIME DISABLED RETIRED

EMPLOYER NAME: _____

EMERGENCY CONTACT: Name _____

Relationship to Patient _____ Phone # _____

INSURANCE: Insurance Plan Name _____

Cardholder Name _____

Relationship to Patient _____ SS # _____ - _____ - _____

DOB _____ Employer Name _____

Information Verification — By signing below, I am indicating that I have completed, reviewed or modified the information above. I have verified that the information is accurate and requires no further changes. I am aware that if my insurance provider fails to pay for the services rendered today due to outdated or incorrect information on this form that I am responsible for the balance.

Patient or Guardian Signature _____ Date _____

GET YOUR RESULTS — PATIENT PORTAL

PATIENT EMAIL COLLECTION & VERIFICATION FORM

FIRST NAME _____ LAST NAME _____

DATE OF BIRTH _____ DATE OF SERVICE _____

We are very excited to offer you the **Doctors Imaging Patient Portal** and hope you will find it helpful and efficient. The portal will provide you with the ability to do the following actions on your own from your computer, smart phone or tablet.

- **view, print, and download your exam reports**
- **view your exam images**
- **share your exam reports and images**
- **view your scheduled appointments and check-in times**
- **save iCalendar appointment reminders to your own calendar**

To join today, please provide your email address below. If you have already subscribed to the portal, please provide your email address again so we may verify our existing records.

Provide email address in the big box below

The Doctors Imaging Patient Portal can only be accessed with an individual email address. Sharing an email address will typically not work as it will be interpreted as a duplicate email address if that email address is already in our system for another patient. If you would like to use an email address that is not the patient's email address (like for an dependent child or parent), please be aware that patient portal access will not be generated if the email provided is already in our system.

What you need to know about the Patient Portal?

1. Your results are usually available on the portal two to three business days after the exam.
2. All of your historical exams are immediately available for your review and use.
3. We no longer email results as you now have the ability to access them or share them yourself.
4. If you need your results sooner we can make them available for you to pickup at the front desk.
5. The patient portal is the quickest and most efficient way to get your results to a new doctor.

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AUTHORIZATION FOR TREATMENT

Name:

Date of Birth:
Medical Record #:
Referring Physician:

I hereby consent to treatment by the attending physician and other medical staff for all local anesthetics, tests, surgical and other medical procedures as deemed necessary by myself and the medical staff.

Authorization For Release Of Information And Assignment Of Benefits

I hereby assign to the above named office, those benefits otherwise payable to me by any third party as reimbursement of expenses and fees in connection with treatment rendered.

I request that payment of authorized benefits be made directly to the medical provider named above on my behalf.

I FULLY UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY AND ALL AMOUNTS NOT OTHERWISE PAID BY MY INSURANCE CARRIER.

I certify that the information on this form given by me for payment under title XVIII (Medicare) is correct and complete. I authorize the holder of medical or related information about me to be released to the Health Care Finance Administration or other health care coverage entity, any information needed for this or any related health care claim in writing or verbally. I further understand and agree to pay for services or amounts due when appropriate. These charges could include amounts applied to my annual deductible co-payment amounts, and charges denied as not covered by my insurance program or deemed medically unnecessary. I understand that well care is not covered by Medicare or many other health insurance programs.

I hereby authorize the release of my films and/or medical records as needed for subsequent medical care. In the event of positive findings, I authorize my attending physician to release the results of my biopsy-surgery to my referring physician named above for their records.

If someone other than the patient is signing this authorization, please state relationship with patient and the reason patient is unable to sign.

Signature _____ **Date Signed:** _____

Do you have a follow-up appointment already scheduled with the physician whom referred you here? YES NO (circle one)

If yes, what is the date/time of your appointment? _____

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RELEASE OF INFORMATION

Patient Name: Date of Birth:

If you have had previous tests done at another facility, please mark what those exams were and at what facility they were performed. If necessary, we will obtain those records as the information contained in them may be helpful in the care we provide you today.

Information Requested:

☐ **X-Ray & Report**	☐ **Operative Report**	☐ **Lab Report**
☐ **X-Ray Films/CD**	☐ **Pathology Report**	☐ **History/Physical**
☐ **Consultation Report**		

Facility_____ Procedure_____ Date performed_____

Release records to: Doctors Imaging Services
Medical Records Department
4204 Teuton Street
Metairie, La. 70006
Phone 504-883-8111
Fax 504-883-3555

I understand that my medical record may also include information on diagnosis/treatment related to psychiatric or psychological conditions, drug and/or alcohol abuse, immune deficiency syndrome (AIDS), and/or HIV status.

I understand that this authorization may be revoke in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire on the following date, event, or condition.

I understand and agree that the information, if any, pertaining to any such diagnosis/treatment described above may be released.

_____

Signature of Patient/Legal Representative

_____

Relationship to Patient and/or Date

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HIPAA ACKNOWLEDGEMENT FORM

Please acknowledge your awareness of our Notice of Privacy Practices by filling in the requested information below, including your signature. By signing this form, you have acknowledged (1) you are aware that DOCTORS Imaging Notice of Privacy Practices is posted in our waiting room and (2) that the DOCTORS Imaging Notice of Privacy Practices is available as a hard copy handout upon request at any time.

Printed Name:

Street Address:

City: State: Zip:

Signature: _____

Date: _____