Front Range Preventive Imaging

Patient Information Form

Today's Date: _____

Last Name: _____ First: _____ MI: ____ Marital Status_____

Sex: M / F Birth Date: ____/____/_____ Age: _____ Height: ____'_____" Weight: _____lbs

Race: Asian Native Hawaiian/Pacific Island Black Caucasian Hispanic Other Declines to report

Ethnicity: Hispanic/Latino Not Hispanic/Latino Declines to report

Primary Language Spoken: English French Indian Spanish Russian Other Declines to Report

To better serve and communicate with you more relevantly we would appreciate your email address. We keep our email list strictly confidential!

Email:_____

Mailing Address: _____Apt / Suite:_____

City: _____ State: _____ ZIP: _____ Phone: (_____)_____

Employer_____Work #:(_____)_____

Emergency Contact_____ PHONE# _____

DO YOU HAVE A HISTORY OF CANCER YES NO WHAT KIND:_____

HAVE YOU HAD A PREVIOUS HEART SCAN (CIRCLE ONE) YES NO WHERE_____

HAVE YOU HAD A PREVIOUS CT SCAN OF YOUR CHEST YES NO WHERE_____

HAVE YOU HAD A PREVIOUS X-RAY OF YOUR CHEST YES NO WHERE _____

How did you hear about us: Friend Radio Newspaper

Website Newsletter Other_____

Referring Physician: _____

The Heart Scan has a weight restriction of less than 300 pounds.

Front Range Preventive Imaging

Heart/Lung Scan

Reason for visit

_____

_____

Medical History:

Elevated Cholesterol No Yes
If you know: HDL _____ LDL _____ Triglycerides _____ Total Cholesterol _____
List your cholesterol medications: _____
_____

Smoking Former No Current
If you smoke: Packs/ day _____ Years smoking _____

High Blood Pressure High Normal Low If high, number of years: _____
(circle one)
List your blood pressure medications: _____
_____

Diabetes	No	Yes	If yes:	Oral medication	Insulin
Chest Pain	No	Yes			
Chest Tightness	No	Yes			
Chest Pressure	No	Yes			
Unusual Cough	No	Yes			
Fatigue	No	Yes			
Dizziness	No	Yes			
Shortness of Breath	No	Yes			
Heart Burn	No	Yes			
Abnormal EKG	No	Yes			
Frequent Palpitations	No	Yes			
Fainting	No	Yes			
Heart Disease	No	Yes	If yes, describe: _____		

Are you currently experiencing any of the above symptoms? If yes, please describe:

_____

_____

Past Pulmonary Medical History

Asthma	No	Yes
Pulmonary fibrosis	No	Yes
Prior lung cancer (less than 5 yr ago)	No	Yes
Prior TB history	No	Yes
Granulomatous disease	No	Yes

***Print Name*_____ *DATE*_____**

Family History:

Does anyone in your family have a history of the following?

Please Check if Yes.

	STROKE	HIGH BLOOD PRESSURE	DIABETES	HEART DISEASE BEFORE AGE 55	HEART DISEASE AFTER AGE 55
PARENT					
SIBLING					
GRANDPARENT					

Your Risk Factors

Asbestos exposure	No	Yes
Radon exposure	No	Yes
Beryllium exposure	No	Yes
Fm History of lung cancer	No	Yes
Exposure to 2nd hand smoke	No	Yes
Recent unintentional Weight loss	No	Yes

Past Coronary/Cardiac Procedures You Have Had: Circle all that apply

CABG (Bypass) Angiography PTCA Coronary Stent Other: _____

Miscellaneous Information

Current level of exercise (circle one)

- Unable to qualify
- None
- Less than 30min. 2-3 times/week
- 30-45min 2-3 times/week
- 45-60min 2-3 times/week
- More than 60min 2-3 times/week

Current level of stress (circle one)

- Unable to qualify
- Low
- Average
- Above average
- High
- Very high

Are you currently taking:

Daily Aspirin	No	Yes
Antioxidants	No	Yes

***Print Name*_____ *DATE*_____**

Front Range Preventive Imaging

Heart/Lung Screening Disclosure and Consent

I voluntarily consent and authorize Front Range Preventive Imaging physicians and technologists to administer the testing required to perform a CT heart/ lung scan.

Furthermore, I understand that:

1. The primary purpose of the lung screening is to detect early cancer or other abnormalities when the likelihood of a cure is greater. □ A normal heart scan does not guarantee that I will not have a heart attack or need treatment for coronary disease.
2. Although this is an excellent tool, it is not perfect and can miss some abnormalities including cancers at the very early stages of development and should not be considered as a substitute for a complete evaluation by a physician.
3. If an abnormality is found a recommendation for additional tests, including subsequent CT or EBCT scans may be made.
4. I will be exposed to radiation during the examination.
5. Since EBCT is very sensitive, it may identify nodules and/or other abnormalities that are insignificant or not cancerous, but may require additional diagnostic tests and/or procedures to evaluate the findings.
6. Such tests and/or procedures may entail additional costs for which I am responsible.
7. Radiology is not a perfect science and it is possible for a radiologist to miss a significant lesion or abnormality by this method.
8. **Front Range Preventive Imaging is not responsible for my follow-up medical care.**
9. **My test results will be made available to the physician of my choice.**

I have been given an opportunity to ask questions about this procedure and the risks and hazards involved and I believe that I have sufficient information to give informed consent. I certify that I have read this form and I understand its contents.

The report for this procedure contains medical terminology that is likely to require interpretation by a physician.

In order to allow patients to take this test, Front Range Preventive Imaging requires that you:

1. Identify the name of a physician below to whom we can send a copy of your medical report.
2. If you are a female, is there any chance you may be pregnant?

YES NO (please circle one) Technologist Initials_____

Are you: (circle one) Self referred or physician referred

Would you like a copy to go to a medical provider YES NO
If YES please provide the following:

I hereby consent that Front Range Preventive Imaging may send a copy of the medical report for this procedure to my physician: I will receive a copy of the report also.

_____
Physician Name

_____
Physician Address

_(_____)_____
Physician Phone Number

Patient Signature _____ Date:_____

Front Range Preventive Imaging

Policy Regarding Messages

In an effort to protect your privacy, we have developed a policy on leaving medical care messages.
We will NOT leave messages with anyone except the patient or legal guardian.
We will NOT leave any information on an answering machine / voice mail.
UNLESS
we have your written permission to do so.
Please read below and consider carefully whom you want to have access to your medical information.

I, _____, give Front Range Preventive Imaging my permission to leave phone messages regarding my medical care and information as listed below. I fully understand that this authorization will remain valid until revoked in writing.

My home / mobile answering machine / voice mail: Phone: (_____)_____

My office / work voice mail: Phone: (_____)_____

My spouse: Name _____ Phone: (_____)_____

Other: Name _____ Phone: (_____)_____

_____ / /
Patient Signature Date

Financial Policy

We are committed to providing you with the best possible care, and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship.

We must emphasize that as health care providers, our relationship is with you, not your insurance company. Any benefits quoted to you are NOT a guarantee of payment from the insurance company.

- Your insurance is a contract between you, your employer, and the insurance company.
- Patients covered under a PPO / HMO plans are responsible for complying with the PPO / HMO rules, regarding written and phone referrals from primary care physicians, if that is a requirement of your plan.
- Failure to comply with the referral requirements of your plan will make it necessary for us to bill you directly for charges incurred during a non-referred visits.
- We will process claims with PPO /HMO plans with which we have a contract agreement, according to that agreement.
- Required co-payments, if applicable, should be made on the day services are provided. You are responsible for all co pays, deductibles, coinsurance, and amounts not covered by your Ins. Co. You will be billed for any balance on your account after the Ins. has paid their portion.

Payment for service is due at the time service is rendered. You are responsible for timely payment of your account, and for any balance remaining after insurance payment has been received. There will be a $25.00 charge for all checks returned for insufficient funds.

I have read the above information; I understand and agree that I am responsible for payment of services rendered.

_____ / /
Patient Signature Date

Boulder Internal Medicine
and
Front Range Preventive Imaging

Notice of Health Information Practices

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Introduction

At Front Range Preventive Imaging, we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice applies to all protected health information as defined by federal regulations.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities.

Obtain an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may refuse your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will agree to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or healthcare item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and healthcare operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.

- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/**
- We will not retaliate against you for filing a complaint.

Your Choices:

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Most sharing of psychotherapy notes

We do not engage in fundraising nor will we ever sell your information for any purpose.

Our Uses and Disclosures

We typically use or share your health information in the following ways.

Treat you: We can use your health information and share it with other professionals who are treating you.
Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization: We can use and share your health information to run our practice, improve your care, and contact you when necessary.
Example: We use health information about you to manage your treatment and services.

Bill for your services: We can use and share your health information to bill and get payment from health plans or other entities.
Example: We give information about you to your health insurance plan so it will pay for your services.

We are allowed or sometimes required to share your information in other ways – usually in ways that contribute to the public good, such as for public health and research. We have to meet many conditions in the law before we can share your information for these following purposes.
For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research: We can use or share your information for health research.

Comply with the law: We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests: We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director: We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Health Information Exchange

We endorse, support, and participate in electronic Health Information Exchange (HIE) as a means to improve the quality of your health and healthcare experience. HIE provides us with a way to securely and efficiently share patients' clinical information electronically with other physicians and healthcare providers that participate in the HIE network. Using HIE helps your healthcare providers to more effectively share information and provide you with better care. The HIE also enables emergency medical personnel and other providers who are treating you to have immediate access to your medical data that may be critical for your care. Making your health information available to your healthcare providers through the HIE can also help reduce your costs by eliminating unnecessary duplication of tests and procedures. However, you may choose to opt-out of participation in the HIE, or cancel an opt-out choice, at any time.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site

I have received and read this Notice of Health Information Practices. I fully understand this Notice and have had all my questions answered.

_____ _____

Print Name Signature Date