

East Side Medical Radiology PLLC

170 East 77th Street - Lower Level

New York, NY 10075

Phone 212-369-9200

Date _____

Patient Last Name _____ First _____

Home Address _____ Apt # _____

City _____ State _____ Zip _____

Country _____

Home Phone _____ Work Phone _____ Cell Phone _____

Date of Birth _____ SS# _____ Sex Male Female

Emergency Contact Name _____ Relationship _____ Phone _____

Name of Employer _____

Employers Address _____

Primary Insurance Name _____

Policy Holder Name _____ Policy Holder Date of Birth _____

Policy # _____ Group # _____

Phone Number of Insurance Company _____

Secondary Insurance Name _____

Policy # _____ Group # _____

Phone # of Secondary Insurance Company _____

Policy Holder Name _____ Policy Holder Date of Birth _____

I authorized the release of any medical or other information necessary to process the claim for services rendered to me. I also request payment of government benefits or commercial insurance benefits to myself or the party who accepts the assignment below.

Name _____ Signature _____ Date _____

I authorize payment of medical benefits to the physician or medical practice for the services rendered.

Name _____ Signature _____ Date _____

East Side Medical Radiology, PLLC
Steven D. Wolff [REDACTED] [REDACTED]
170 E 77th St., New York, NY 10075 (212)369-0200

HIPAA PRIVACY NOTICE

- I acknowledge that I have been given a copy of the Practice's "HIPAA Privacy Notice" which describes the Practice's obligations to ensure the privacy of my health information. The HIPAA Privacy Notice also describes how the Practice may use and disclose my health information for treatment, payment and health care operations. I know that I have the right to review the Practice's HIPAA Privacy Notice and to ask questions about it. I understand the Practice is required to maintain the privacy of my health information in accordance with the terms of its HIPAA Privacy Notice.
- I further acknowledge that the Practice can change its HIPAA Privacy Notice in the future, and that I can receive a copy of the Practice's current Privacy Notice at any time by contacting the Privacy Officer.
- I understand that I have a right to request that the Practice restrict its uses and disclosures of my health information for treatment, payment, or health care operations. If my restrictions are accepted by the Practice, these restrictions will be binding on the Practice. I also understand that the Practice is not required to agree to my requested restrictions.
- I do not request any restrictions on the Practice's use or disclosures of my health information for treatment, payment or health care operations. _____(initial).
- I do request specific restrictions, as listed below, on the Practice's use or disclosures of my health information for treatment, payment or health care operations. _____(initial).
- By signing this form, I consent to the Practice's use and disclosure of my health information for treatment, payment and healthcare operations. I understand that I have the right to revoke this consent at any time in writing, but if I do, my revocation will not influence any actions the Practice has already taken in reliance on this consent.

Authorization to Obtain or Release Medical Records from Medical Providers

I hereby authorize East Side Medical Radiology PLLC to obtain any and all medical records specifically related to my current condition from any physician, hospital, or other health care professional that has provided medical care to me in relation to my current condition in the past. _____(initial).

I also authorize the Practice to release any and all medical records, physically or verbally, concerning my care to the following specified parties:

Referring Physician	Consent Required
Insurance Company, Medicare, Medicaid, Third Party Administrator, Managed Care Company	Consent Required
Additional Party Name	Relationship to Patient
1.	
2.	
3.	
4.	
5.	

Authorization to Obtain or Release Medical Information to Individual/Family Members

In accordance with Federal government privacy rules implemented through the Healthcare Portability Act of 1996 (HIPAA), in order for your physician or staff of the Practice to discuss your condition with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical conditions, the law stipulates that these rules may be waived.

_____ (initial) I authorize the Practice to release any or all information, in any form of communication, concerning my medical care as set forth above.

Patient's Signature: _____ **Print Patient's Name** _____

Date: _____

Summary Notice of Privacy Practices

THIS SUMMARY DESCRIBES HOW MEDICAL INFORMATION ABOUT OUR PATIENTS MAY BE USED AND DISCLOSED AND HOW PATIENTS CAN GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW THE SUMMARY. THE FULL NOTICE IS AVAILABLE UPON REQUEST.

Our practice is required by law to maintain the privacy of confidential information and to provide individuals with notice of its legal duties and privacy practices with respect to such information. We reserve the right to change the terms of notice and make the new notice provisions effective for all confidential information we maintain. We will provide written revised notice.

Uses and Disclosure of Protected Health Information (PHI)

- You will be asked to sign a consent form which permits us to use your PHI for treatment, payment and health care operations.
- Other uses of your PHI will be made only with your written authorization.
- We may disclose information to a person or persons you identify.
- We may disclose information in the event of an emergency and in a situation where we are unable to obtain consent from you due to your communication barriers.
- We may contact you to provide appointment reminders, test results, or information about treatment alternatives or other health related benefits and services. In the event of your absence, we may leave a message at your home or office unless otherwise advised by you.

Disclosures that may be made without your consent

- Required by law
- Public Health Issues
- Communicable diseases
- Health oversight
- Abuse or neglect
- Food and Drug Administration issues
- Legal proceedings in response to court order
- Law enforcement issues
- Coroners, Funeral Directors, and organ donation
- Research
- Criminal activity
- Military activity and National Security
- Worker's Compensation
- Inmates
- Required Users

Patient Rights

- Inspect and copy your protected health information
- Request restrictions of your protected health information
- Receive confidential communications by alternative means or at an alternative location
- Request amendment of protected health information
- Receive an accounting of certain disclosures made by us
- Obtain a paper copy of complete notice from us

Name: _____

Date of Birth: _____ Height: _____ Weight: _____ Social Security #: _____

Some of the following items may be hazardous to your safety or can interfere with you MRI/MRA examination. Please check YES or NO for each of the following items.

YES	NO	
		Cardiac Pacemaker or Defibrillator
		Brain Aneurysm clip (s)
		Transdermal Patch: Nicotine / Nitroglycerine
		Shunts (e.g. Spinal / Intraventricular/ VP shunt)
		Bone Growth /Fusion stimulator
		Neurostimulator
		Cochlear /Otologic / Ear Implant
		Implanted Drug Infusion Device / Insulin Pump
		Electrodes (on body, head or brain)
		Any Implant Held in Place by Magnet
		Carotid Artery Vascular Clamp
		Intravascular stents, filters, or coils
		Vascular Access Port and/or Catheter
		Swan-Ganz Catheter
		Internal Pacing Wires
		Any type of prosthesis: eye,penile, etc
		Metal or Wire Mesh Implants
		Harrington Rods (spine)
		Joint Replacement
		Bone/Joint pin, screw, nail, wire, plate
		Body piercing (s)
		Tattooed Makeup (eyeliner, lips, etc)
		Any Metal Fragments
		IUD or Diaphragm
		Hearing aid (remove before MRI/MRA)
		Dentures (remove before MRI/MRA)
		Asthma or other breathing disorder
		Anxiety
		Other:

1. What problems are you having that made the doctor order this study?

2. Have you ever been to the hospital for an invasive procedures or surgery? Yes / No
 Date Reason

3. Have you ever had an accident that required metal fragments to be removed from your eye?
4. Women: Could you be pregnant? Yes / No
5. Do you have a history of kidney disease? Yes / No
6. Do you have sickle cell anemia? Yes / No
7. Have you had an allergic reaction that required emergency treatment? Yes / No
8. Do you or have you:
 High blood pressure? Yes / No
 Diabetes? Yes / No
 High cholesterol? Yes / No
 Smoked tobacco? Yes / No
9. Do you have chest pain? Yes / No
 If yes:
 Is it substernal? Yes / No
 Is it brought on by exertion or emotional stress? Yes / No
 Is it relieved by rest or nitroglycerine? Yes / No

Patient Signature: _____

Date: _____

INFORMED CONSENT FOR MRI CONTRAST INJECTION

As part of your scan we may need to inject you with a contrast solution containing gadolinium. This clear, colorless liquid is removed from your body by your kidneys and will not alter the appearance of your urine. It will show up on images to provide important diagnostic information.

During the injection, it is common to feel a cool sensation near the injection site or experience a slight metallic taste. These stop almost immediately after the injection is completed. Rarely, a more serious reaction can occur that could affect your breathing or lower your blood pressure. Your personal physician is aware of the risk of complications, but feels that the diagnostic information to be obtained outweighs the small risk of the injection.

We take every precaution to obtain a good examination with maximum safety. There is some risk in not having the examination that your doctor has requested. If this examination is not done with this injection, your doctor may not be able to as accurately diagnose your condition.

I, _____, have read and understood the above and give consent to have a gadolinium injection. I understand that despite every skill and prudent effort made to avoid complications during the examination, there is no guarantee a complication will not occur.

Signature of Patient/Parent/Guardian

Date

Signature of Witness