inview Imaging
BRAD M. PIATT, MD & ASSOCIATES

PATIENT NAME AND DATE OF BIRTH

Last Name | First Name | Date of Birth

DEMOGRAPHICS Required by the Federal Government

Preferred Language: ☐ English ☐ Chinese ☐ German ☐ Italian ☐ Japanese ☐ Polish ☐ Portuguese ☐ Russian ☐ Spanish ☐ Other

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

PATIENT HISTORY

CURRENT MEDICATIONS Include those you buy without a prescription

☐ No Current Medications

MEDICAL HISTORY

MARK (C) FOR CURRENT PROBLEMS. CHECK (X) AND INDICATE AGE WHEN YOU HAD ANY OF THE FOLLOWING SYMPTOMS OR DISEASES.

Anemia		Epilepsy		Hypertension		Polio	
Arthritis/Rheumatism		German Measles		Jaundice/ Hepatitis		Psoriasis	
Bleeds Easily		Glaucoma		Kidney Stones		Rheumatic Fever	
Cancer		Gout		Measles		Stroke	
Chicken Pox		Heart Disease		Migraines		Tuberculosis	
Crohn's / Colitis		Hernia		Mumps		Thyroid Disease	
Diabetes		Herpes		Osteoporosis		Varicose Veins / Phlebitis	
Diverticulosis		High Cholesterol		Peptic Ulcer		Venereal Disease	
Eczema		Hives		Pneumonia / Pleurisy			

SMOKING HISTORY

☐ Current Every Day Smoker
☐ Current Some Day Smoker
☐ Former Smoker
☐ Non Smoker

DRUG ALLERGIES

☐ No Known Drug Allergies ☐ Ace Inhibitors ☐ Aspirin ☐ Codeine ☐ Macrolides
☐ Sulfas ☐ NSAIDS ☐ Penicillins ☐ Tetracyclines

Other:

PATIENT SIGNATURE _____ DATE _____

PATIENT INFORMATION				
SS#:	Last Name:		First Name:	
Middle:		DOB:		
Gender:			Marital Status:	
Address:				
City:	State:	Zip:		
Home Phone	Cell Phone		Work Phone:	
Employer:		Occupation:		
Employer Address:				
City:	State:	Zip:		
PRIMARY INSURANCE				
Insurance Company:	ID#:	Group#:		
SECONDARY INSURANCE				
Insurance Company:	ID#:	Group#:		

ATTENTION ALL MEDICARE PATIENTS. Please list all medical insurance policies that you have in addition to Medicare.

AUTHORIZATION FOR RELEASE OF INFORMATION: I hereby authorize INVIEW MEDICAL IMAGING to release all information necessary to secure payment from my insurance carrier(s) and Medicare (if applicable).

SIGNATURE _____ DATE _____

NOTICE OF PRIVACY PRACTICES
PATIENT ACKNOWLEDGEMENT

PATIENT'S NAME		
Last Name	First Name	Middle Initial

I have read the Notice of Privacy Practices and understand my rights contained in the Notice.

By way of my signature, I provide Inview Imaging with my authorization and my consent to use and disclose my protected information for purpose of treatment, payment and healthcare operations as described the Notice of Privacy Practices.

PATIENT'S OR AUTHORIZED SIGNATURE

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 this carefully.**

Inview Imaging is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

DISCLOSURE OF YOUR HEALTH CARE INFORMATION

TREATMENT

We may disclose your healthcare information to other healthcare professionals within Inview Imaging for the purpose of treatment, payment or healthcare operations.

Example

"On occasion, it may be necessary to seek consultation regarding your condition from other healthcare providers associated with Inview Imaging."

PAYMENT

We may disclose your health information to your insurance provider for the purpose of payment or healthcare operations.

Example

"As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to Inview Imaging for healthcare services rendered. If you pay for your healthcare services personally, we will, as a courtesy provide an itemized billing to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information such as, diagnosis, date of injury, and codes which describe the healthcare services you received."

WORKERS COMPENSATION

We may disclose your health information as necessary to comply with State Workers Compensation Laws.

EMERGENCIES

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care, about you medical condition or in the event of an emergency or of your death.

PUBLIC HEALTH

As required by law, we may disclose your health information to public authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medication, and reporting disease or infection exposure.

JUDICIAL AND ADMINISTRATIVE PROCEEDINGS

We may disclose your health information in the course of any administrative or judicial proceeding.

LAW ENFORCEMENT

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

DECEASED PERSONS
We may disclose your health information to coroners or medical examiners.

ORGAN DONATION
We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

RESEARCH
We may disclose your health information to researchers conducting research that has been approved by an institutional review board.

PUBLIC SAFETY
It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

SPECIALIZED GOVERNMENTAL AGENCIES
We may disclose your health information for military. National security, prisoner and government benefits purposes.

CHANGE OF OWNERSHIP
In the event that this facility is sold or merged with another organization, your health information record will become the property of the new owner or entity.

MARKETING
We may contact you for marketing purposed or fundraising purposes.

Examples

"As a courtesy to our patients, it is our policy to call your home on the evening prior to your scheduled appointment to remind you of your appointment time. If you are not at home, we leave a reminder message on your answering machine or with the person answering the phone. No personal health information will be disclosed during this recording or massage other than the date, time and location of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment."

"It is our practice to participate in charitable events to raise awareness, or for food donation, gifts, money, etc. During these times, we may send you a letter, postcard, or other correspondence or call your home to invite you to participate in the charitable activity. We will provide you with information about the type of activity, the dates and times, request your participation in such an event. It is not our policy to disclose any personal health information about your condition for the purpose of facilitating fundraising events."

YOUR HEALTH INFORMATION
You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however that Inview Imaging is not required to agree to the restriction that you may request.

You have the right to have your health information received or communicated through an alternate method or sent to an alternative location other than the usual method of communication or delivery upon request.

You have the right to inspect and copy your health information

You have to request that this facility amend your protected health information. Please be advised, however, that Inview Imaging is not required to agree to amend your protected health information. If your request to amend your

health information has been denied, you will be provided an explanation of our denial reason(s) and information about how you can disagree with the denial.

You have a right to a paper copy of this Notice of Privacy Practices. We have made this notice in a format easily printed from our website.

CHANGES TO THIS NOTICE OF PRIVACY PRACTICES

Inview Imaging reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, Inview Imaging is required by law to comply with this Notice.

Inview Imaging is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information.

COMPLAINTS

Complaints about your privacy right, or how Inview Imaging has handled your health information should be directed to our Privacy Officer. Contact Us with any complaints. If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, SW
Room 509F HHH Building
Washington, DC 20201