ASHLEY RIDGE IMAGING CENTER

Patient's Full Name: _____
(Last) (Suffix) (First) (MI)

Single ☐ Married ☐ Divorced ☐ Widowed ☐ Date of Birth_____ SS#_____

Race: American Indian☐ Asian☐ Black☐ Caucasian☐ Hispanic☐ Language: English ☐ Other_____

Mailing Address_____ Physical Address_____

City_____ State_____ ZIP_____ Male ☐ Female☐

Home Phone_____ **Work** Phone_____ **Cell** Phone _____ Email_____
☐ I give my permission to be contacted by Email

Employer_____ **Address**_____

Emergency Contact (Outside the home) Name:_____ Relationship: _____ Phone_____

How did you hear about Ashley Ridge? ☐ **Physician** ☐ **Friend** ☐ **Previous Appointment Here**
☐ **Newspaper** ☐ **Magazine** ☐ **Radio** ☐ **Other** _____

Responsible Party _____ Relationship_____

Address_____ City_____ State_____ ZIP_____

Date of Birth_____ **SS#**_____ Male ☐ Female☐

Employer_____ Work Phone_____

Primary Insurance _____ Address _____ _____

Member Name_____ Policy #_____ Group #_____

Member Date of Birth_____ SSN:_____ Employer _____

Secondary Insurance _____ Address _____ _____

Member Name_____ Policy #_____ Group #_____

Member Date of Birth_____ SSN:_____ Employer _____

Referred By _____

Is this visit related to an injury? Yes ☐ No ☐ Date of Injury_____ Place of Injury _____

Workers Comp Carrier:_____ Adjuster:_____ Claim#_____

Is this visit subject to payment for a Liability Claim? ☐ Yes ☐ No Carrier: _____

I authorize Ashley Ridge Imaging Center to file my insurance and I request that payment of health insurance benefits and 3rd Party Payor benefits be made on my behalf to Ashley Ridge Imaging Center for any services furnished me. I authorize any holder of medical information to release to my health insurance carrier, the health care financing administration and its agents or any other 3rd party payor any information needed to determine these benefits or benefits payable for related services. I understand that I may purchase a copy of my MRI films. Ashley Ridge Imaging Center utilizes Diagnostic Imaging Associates and Radiology Imaging Associates for interpretation of MRI scans. I understand I will receive a separate bill for the interpretation of my exam.

SIGNATURE_____ DATE_____

Ashley Ridge Imaging Center
ULTRASOUND MEDICAL HISTORY

Name _____ Date of Birth _____
Height _____ Weight _____ Last time you ate/drank anything _____

Clinical History
Reason for exam/complaint:

_____

How long have you had this problem?

_____

Have you had any other tests for this problem in the past?_____
If so, When? _____ Where? _____
Allergies?_____

If female, Date of your last menstrual period: _____

Family History: Please check each medical problem, if anyone in the family has or has had these problems:

__ Alcohol/Drugs	__ Depression	__ Endocrine Problems	__ Kidney
__ Anemia	__ Dermatitis	__ Endometriosis	__ Liver
__ Blood Clots	__ Diabetes	__ Heart Disease	__ Seizures
__ Cancer	__ Eating Disorders	__ High Blood Pressure	__ Thyroid

List of Medications:

_____
_____

If you have had any surgeries, please list:

_____
_____

Patient/Guardian Signature _____ Date _____

Technician Notes:

_____

_____

Ashley Ridge Imaging Center
463 Ashley Ridge Boulevard, Suite 200
Shreveport, LA 71106

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS

I consent to the use or disclosure of my protected health information by Ashley Ridge Imaging Center for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Ashley Ridge Imaging Center. I understand that diagnosis or treatment of me by Ashley Ridge Imaging Center may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Ashley Ridge Imaging Center is not required to agree to the restrictions that I may request. However, if Ashley Ridge Imaging Center agrees to a restriction that I request, the restriction is binding. I have the right to revoke this consent, in writing, at any time, except to the extent that Ashley Ridge Imaging Center has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Ashley Ridge Imaging Center's Notice of Privacy Practices prior to signing this document. Ashley Ridge Imaging Center's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Ashley Ridge Imaging Center. The Notice of Privacy Practices for Ashley Ridge Imaging Center is also provided in the patient waiting area. This Notice of Privacy Practices also describes my rights and Ashley Ridge Imaging Center's duties with respect to my protected health information.

Ashley Ridge Imaging Center reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

The Health Insurance Portability Act of 1996 (HIPAA) grants you the right to designate one or more individuals to act on your behalf regarding the protection of health information that pertains to you. You may designate an individual to be your personal representative below. This person shall be given all of the privileges that would belong to you regarding your health information. Your designation can be revoked at any time by signing a revocation and delivering it to Ashley Ridge Imaging Center. However, any revocation will not apply to the extent that persons authorized to use or disclose the health information have already acted in reliance on your previous designation.

Name of Patient (please print)	**Name of Designated Personal Representative**
Signature of Patient	**Relationship of Personal Representative to you**
Date	

REVOCATION SECTION: I hereby revoke my designation of a personal representative.

Signature of Patient	**Date**

ASHLEY RIDGE IMAGING CENTER

Assignment of Benefits / Financial Policy

_____ DOB:_____

Patient Name (Please Print)

_____

Responsible Party (Please Print)

****

YOU WILL RECEIVE A SEPARATE BILL FROM RADIOLOGY IMAGING ASSOCIATES or DIAGNOSTIC IMAGING ASSOCIATES FOR THE READING OF YOUR TEST

_____ _____

Date Signature of Responsible Party

****

I authorize payment of medical benefits under any insurance policy(ies) or other settlement, if any, to Ashley Ridge Imaging Center for the technical component of my test and to the radiology group for the professional reading of my test.

I agree to pay Ashley Ridge Imaging Center for all charges in excess of the amounts paid by my insurance policy(ies). I understand it is my responsibility to determine whether your services are covered by my insurance policy(ies) and to verify preauthorization requirements. Your insurance policy is a contract between you and your insurance company and the filing of insurance forms does not constitute payment of any portion of the bill.

All applicable co-pays, deductibles and coinsurance amounts are due at the time of service. As a courtesy to our patients, we file insurance claims for you.

I agree to pay Ashley Ridge Imaging Center for copayments, deductibles or charges for service which are not covered under my insurance contract. If this is a liability claim, I understand that I am fully responsible for payment of this claim.

_____ All patient balances over 60 days past due will accrue interest at a rate of 9% APR.
Initial

_____ If your account has to be forwarded to a collection agency you will be assessed collection fees in
Initial the amount of 25% of the balance owed.

_____ A fee of $25 will be charged for all checks returned to us as unpaid by your bank.
Initial

_____ _____

Date Signature of Patient

_____ _____

Date Signature of Responsible Party