FOR OFFICIAL WASHINGTON RADIOLOGY USE ONLY
PLACE PATIENT LABEL HERE

PATIENT INFORMATION

WASHINGTON RADIOLOGY

PI

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SHADED FIELDS ARE MANDATORY

WE ARE EXCITED TO ANNOUNCE THAT WE HAVE TRANSITIONED TO A NATIONALLY CERTIFIED ELECTRONIC HEALTH RECORDS KEEPING SYSTEM (EHR). AS PART OF THIS CHANGE, WE ARE REQUESTING ADDITIONAL PATIENT DATA THAT WILL HELP US FULLY UTILIZE THE EHR. ADDITIONALLY, WE ARE ASKING FOR PATIENT DEMOGRAPHIC INFORMATION (SUCH AS RACE AND ETHNICITY) THAT IS REQUIRED BY THE GOVERNMENT FOR US TO MAINTAIN OUR PARTICIPATION WITH FEDERAL INSURANCE PROGRAMS, INCLUDING MEDICARE. WE HAVE TAKEN APPROPRIATE MEASURES TO COMPLY WITH HEALTHCARE PRIVACY AND SECURITY REGULATIONS. WE HAVE POLICIES, PROCEDURES, AND SAFEGUARDS IN PLACE TO PREVENT UNAUTHORIZED ACCESS TO OUR PATIENTS' RECORDS. WE ALSO HAVE PROVISIONS FOR BACKUP AND DISASTER RECOVERY OF YOUR MEDICAL RECORD IN CASE OF FIRE, WATER DAMAGE, ETC. WE APPRECIATE YOUR COOPERATION AND PATIENCE IN COMPLETING THIS FORM!

LAST NAME, FIRST NAME MI	DATE OF BIRTH	GENDER

RACE

☐ AMERICAN INDIAN OR ALASKA NATIVE ☐ ASIAN ☐ BLACK OR AFRICAN AMERICAN ☐ NATIVE HAWAIIAN OR PACIFIC ISLANDER ☐ WHITE ☐ OTHER ☐ DECLINE TO ANSWER

ADDRESS	APT NO	CITY, STATE ZIP

HOME PHONE	WORK PHONE	CELL PHONE	EMAIL ADDRESS

CONTACT PREFERENCE:	CIRLCLE ONE:
☐ MOBILE ☐ HOME ☐ WORK	I AGREE / I DO NOT AGREE TO ALLOW ELECTRONIC COMMUNICATION VIA EMAIL/TEXT

EMPLOYER OR SCHOOL NAME

EMERGENCY CONTACT NAME	EMERGENCY CONTACT PRIMARY PHONE	RELATIONSHIP

DO YOU SPEAK ENGLISH?	OTHER LANGUAGES SPOKEN
☐ YES ☐ NO	

SMOKING STATUS

☐ SMOKE EVERY DAY ☐ SMOKE BUT ONLY SOME DAYS ☐ FORMER SMOKER ☐ HEAVY SMOKER ☐ LIGHT SMOKER ☐ NEVER SMOKED

ETHNICITY	HEIGHT	WEIGHT	ESTIMATED BLOOD PRESSURE
☐ HISPANIC OR LATINO ☐ NON HISPANIC	FT IN	LBS	SYSTOLIC DIASTOLIC

LIST ALLERGIES	SEVERITY (MILD, MODERATE, SEVERE)	LIST CURRENTLY PRESCRIBED MEDICATIONS	DOSAGE

CAN YOU STAND UNASSISTED FOR A MINIMUM OF 10 MINUTES?	☐ YES ☐ NO	WHAT TYPE OF SUPPORT DO YOU REQUIRE FOR STANDING AND WALKING? (I.E. CANE, WALKER, ADDITONAL PERSON, HOYER LIFT, OTHER, NONE)	
HAVE YOU FALLEN IN THE PAST 6 MONTHS?	☐ YES ☐ NO		

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME	POLICY NUMBER	GROUP NUMBER	NAME OF PRIMARY POLICY HOLDER	POLICY HOLDER DOB	RELATIONSHIP TO PATIENT
SECONDARY INSURANCE COMPANY NAME	POLICY NUMBER	GROUP NUMBER	NAME OF PRIMARY POLICY HOLDER	POLICY HOLDER DOB	RELATIONSHIP TO PATIENT

PHYSICIAN INFORMATION

REFERRING PHYSICIAN NAME AND ADDRESS

OTHER PHYSICIAN NAME AND ADDRESS

EXAM INFORMATION

DATE AND DESCRIPTION OF PRIMARY EXAM AND REASON

PATIENT AUTHORIZATIONS

1) I HEREBY AUTHORIZE WASHINGTON RADIOLOGY TO APPLY FOR HEALTHCARE BENEFITS ON MY BEHALF FOR THE SERVICES RENDERED. I REQUEST THAT THE PAYMENTS FROM ANY GOVERNMENT-SPONSORED HEALTHCARE PROGRAM, INSURANCE COMPANY, OR INDEPENDENT CARRIER WITH WHICH WRA CONTRACTUALLY PARTICIPATES BE MADE DIRECTLY TO WR. I CERTIFY THAT THE INSURANCE INFORMATION ABOVE IS CORRECT.
2) I AUTHORIZE THE RELEASE OF ANY MEDICAL RECORDS TO WASHINGTON RADIOLOGY AS REQUIRED BY THE MQSA TO MAINTAIN ACCREDITATION.
3) I AUTHORIZE RELEASE OF ANY NECESSARY INFORMATION, INCLUDING PROTECTED HEALTH INFORMATION (PHI) FOR THIS OR ANY OTHER CLAIM, TO ANY GOVERNMENT-SPONSORED HEALTHCARE PROGRAM, INSURANCE COMPANY, OR INDEPENDENT CARRIER FOR THE PURPOSE OF OBTAINING REIMBURSEMENT FOR THE SERVICES RENDERED. IN ADDITION TO HEALTH INSURANCE COMPANIES AND TREATING PHYSICIANS, I FURTHER AUTHORIZE RELEASE OF MY MEDICAL INFORMATION TO:

NAME	RELATIONSHIP
NAME	RELATIONSHIP

I UNDERSTAND THAT I HAVE THE RIGHT TO RECEIVE, UPON REQUEST, A COPY OF WRA'S NOTICE OF PRIVACY PRACTICES WHICH DESCRIBES HOW WR MAY DISCLOSE MY PHI. FAILURE TO PROVIDE REQUESTED INFORMATION, OR TO AUTHORIZE RELEASE OF PHI, MAY RESULT IN NON-PAYMENT OF MY CLAIM BY MY INSURANCE COMPANY. I FURTHER ACKNOWLEDGE THAT ALL SERVICES RENDERED ARE THE FINANCIAL LIABILITY OF THE PATIENT OR GUARANTOR AND I MAY BE HELD LIABLE FOR WRA'S FEES DUE TO NON-PAYMENT BY MY INSURANCE COMPANY. PATIENTS WITH A CREDIT BALANCE WITH WR MANAGEMENT AGREE TO APPLY CREDIT BALANCE TO ANY OPEN CHARGES. I ALSO PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL. THESE AUTHORIZATIONS MAY BE REVOKED BY ME, IN WRITING, AT ANY TIME.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN	DATE