Patient Acknowledgement of Receipt of Notice

This is to acknowledge that I have received and reviewed notice of Privacy Practices. Should I have any questions regarding the Notice of Privacy Practices, I understand that I can contact HIPPA Privacy Officer.

Patient signature: _____

Date: _____

MEDICAL RELEASE:

This is been advised

to release to my Physician, Attorney and Insurance Company a full report or films containing my diagnosis, treatment, etc. upon their request.

Date:_____ Signature:_____
(Patient or parent of minor patient)

I have been advised to have an x-ray (s) by my physician Dr._____, I understand that you do not routinely perform x-ray (s) examination on pregnant patients. I am totally aware of the remote possibility of injury to my fetus or myself, but I chose to accept that responsibility.

Date:_____ Signature:_____
(Patient or parent of minor patient)

PLEASE CIRCLE ONE OF THE FOLLOWING:

☐ **I AM PREGNANT**

☐ **I AM NOT PREGNANT.**

☐ **I DO NOT KNOW IF I AM PREGNANT.**

AUTHORIZATION OF DIRECT PAYMENTS AND LIEN

RE: Patient Records and Lien

I do herby authorize

to furnish you, my attorney, with a full report of diagnostic test or any treatments performed on myself in regard to the accident in which I was involved on

I hereby authorize and direct you, my attorney, to pay directly to , such sums as may be necessary to adequately compensate , for medical services rendered me both reason of this accident and by reason of any other bills that are due this office and to withhold such sums from any settlement, judgment or verdict as may be necessary to protect said

Prior to my being seen by

,

I executed an insurance assignment and payment order, whereby I directed the insurance company responsible or the paymen of my medical expenses to pay

directly,for services rendered. I understand that I am personally and fully responsible to

,

for services rendered to me and that this agreement is made

solely for the additional protection, and in consideration of I awaiting payments.

Dated: _____ Patient's Name _____

Patient's Signature _____

The undersigned, being the attorney of record for the above patient does hereby acknowledge receipt of the above lien.

Dated: _____ Attorney's Signature _____

Attorney: * Please date, sign and return one copy to our office
* Keep one copy for your records

MEDICAL QUESTIONAIRE

Briefly explain your problem:_____

_____

_____

How long have you had this problem ?_____

Is this the result of a car accident or job injury ?_____

If so, please give date:_____

Which medical illnesses do you have ?

_____

Have you ever been diagnosed with a tumor or cancer ?_____

List previous surgeries and operations: _____

_____

_____

NAME:_____DATE:_____

TECHNOLOGISTS USE ONLY:

IV CONTRAST? (☐) YES (☐) NO HOW MUCH? _____ CC _____

BY WHOM ? DR. _____DATE: _____

MRI OF ? _____ TECH : _____

PERMISSION FORM

DATE: _____

_____DOA:_____

To Whom It May Concern:

I, _____GIVE PERMISSION FOR MY
{PLEASE PRINT}
SON/DAUGHTER {SEE HIS/HER NAME LISTED ABOVE} TO RECEIVE DIAGNOSTIC TESTS AT THE OFFICE OF

AT

_____

{SIGNATURE PARENT/GARDIAN}