PATIENT DEMOGRAPHIC FORM

MD Imaging
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DATE_____

NAME:_____

ADDRESS_____

CITY_____ STATE_____ZIP_____

REFERRING PHYSICIAN_____

DOB:_____ SOC.SEC.#:_____

EMPLOYER_____

PHONE#:(DAYTIME)_____ (HOME)_____ (CELL)_____

PRIMARY INSURANCE INFORMATION:_____

ADDRESS:_____ID#:_____

PRIMARY INSURANCE HOLDER_____

SECONDARY INSURANCE:_____

DATE OF BIRTH_____ SOC. SEC. #:_____

NO FAULT/WORKERS COMP (if applicable)_____

CLAIM#:_____ **POLICY#**:_____

DATE OF ACCIDENT:_____

LAWYER (Name, Address, Phone#)_____

_____

HOW DID YOU HEAR ABOUT US? _____PHYSICIAN _____RADIO _____TV ___

PATIENT _____OTHER (EXPLAIN)_____

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Each time you visit a healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, a plan for future care or treatment, and billing-related information. This Notice applies to all of the records of your care generated by your health care provider.

Our Responsibilities

Medical Diagnostic Imaging, PLLC is required by law to maintain the privacy of your health information and to provide you with a description of our legal duties and privacy practices regarding your health information. The current Notice will be posted in the waiting area. The notice will include the effective date. In addition, we will make our best effort to provide you with a copy of this notice that we request you acknowledge with your signature.

We are required by law to abide by the terms of this Notice and notify you if we make changes to this Notice, which may be at any time. Changes to the Notice will apply to your medical information that we already maintain as well as new information received after the change occurs. If we change our Notice, it will be posted in the waiting area. You may also request that a revised Notice be sent to you in the mail or you may ask for one at your next appointment or appropriate visit. This Notice will also serve to advise you as to your rights with regard to your medical information.

How We May Use and Disclose Medical Information About You.

The following categories describe examples of the way we use and disclose medical information:

For Treatment: We may use medical information about you to provide, coordinate and manage your treatment or services. We may disclose medical information about you to referring doctors, nurses, technicians, or other personnel who are involved in your care. We may also provide a subsequent healthcare provider with copies of various reports upon request that should assist him or her in treating you.

For Payment: We may use and disclose medical information about your treatment and services to bill and collect payment from you, your insurance company or a third party payer. For example, we may need to give your insurance company information before it approves or pays for the health care services we recommend for you. If you pay for a service or health care item out-of-pocket in full, you can request us not to share that information for the purpose of payment or our operations with your health insurer. We will comply with that request unless a law requires us to share the information.

For Health Care Operations: We may use or disclose, as needed, your health information in order to support our business activities. These activities may include, but are not limited quality assessment activities, employee review activities, training of medical staff, licensing, legal advice, accounting, billing collections support and conducting or arranging for other business activities. For example, we provide medical records to a storage company for long-term safekeeping. In addition, we may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment by telephone.

Business Associates: There are some services provided in our organization through contracts with business associates. Examples include quality assurance, accounting, legal services, and billing and collection services. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job that we have asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information through a written contract.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Consent, Authorization or Opportunity to Object

We also may use and disclose your health information as set forth below. You have the opportunity to agree or object to the use or disclosure of all or part of your health information in these instances. If you are not present or able to agree or object to the use or disclosure of the health information (such as in an emergency situation), then your clinician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the information that is relevant to your health care will be disclosed.

1. Individuals Involved in Your Care or Payment for Your Care: You have the right and choice to tell us to share information with your family, close friends, or others involved in your care or helps pay for your care. All requests must be submitted in writing. If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

2. Future Communications: We may communicate to you to remind you that you have an appointment for medical care. If you are not interested in receiving these materials, please contact our Privacy Officer. You can ask us to contact you in a specific way(for example, home or mobile phone) or to send mail to a different address. We will comply with all reasonable requests.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Object

We may use or disclose your health information in the following situations without your authorization or without providing you with an opportunity to object. These situations include:

As required by law. We may use and disclose health information to the following types of entities, including but not limited to:

Food and Drug Administration
Public Health or Legal Authorities charged with preventing or controlling disease, injury or disability
Correctional Institutions
Workers Compensation Agents
Organ and Tissue Donation Organizations
Military Command Authorities
Health Oversight Agencies
Funeral Directors, Coroners and Medical Directors
National Security and Intelligence Agencies
Protective Services for the President and Others
Authority that receives reports on abuse and neglect Law Enforcement/Legal Proceedings: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

State-Specific Requirements: Many states have requirements for reporting including population-based activities relating to improving health or reducing health care costs.

Your Health Information Rights

Although your health record is the physical property of the Medical Diagnostic Imaging, PLLC, you have the right to:

Inspect and Copy: You have the right to inspect and copy medical information that may be used to make decisions about your care. We ask that you submit these requests in writing. Usually, this includes medical and billing records, but does not include psychotherapy notes or information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review. Requests for access to and copies of your medical information must be submitted to Medical Diagnostic Imaging, PLLC in writing. The charge for copies of medical information is 0.75 cents per page

Amend: If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information by submitting a request in writing. You have the right to request an amendment for as long as we keep the information. We may deny your request for an amendment and if this occurs, you will be notified of the reason for the denial in writing within 60 days.

An Accounting of Disclosures: You have the right to request an accounting of our disclosures of medical information about you except for certain circumstances, including disclosures for treatment, payment, health care operations or where you specifically authorized a disclosure. Medical Diagnostic Imaging, PLLC will provide the first accounting to you in any 12-month period without charge. Medical Diagnostic Imaging, PLLC will impose a fee of $10.00 each subsequent request for an accounting within the 12-month period. We ask that you submit these requests in writing.

Request Restrictions: You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a procedure that you had. We ask that you submit these requests in writing. *We are not required to agree to your request.* If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. We will agree to the request to the extent that it is reasonable for us to do so. For example, you can ask that we use an alternative address for billing purposes. We ask that you submit these requests in writing.

A Paper Copy of This Notice: You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

To exercise any of your rights, please obtain the required forms from the Privacy Officer and submit your request in writing.

Questions/Complaints

If you have questions regarding this notice, please contact the privacy officer listed below. If you believe your privacy rights have been violated, you may file a complaint with us by calling (845) 471-2848 and asking for the Privacy Officer or by contacting the US Department of Health and Human Services Office for Civil Rights. You will not be penalized for filing a complaint.

Other Uses of Medical Information

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. However, we are unable to take back any disclosures we have already made with your permission and we are required to retain our records of the care that we provided to you.

Privacy Officer: Julie Paradiso
Telephone Number: (845) 471-2848
Current Effective Date: 01/04/2014

MD Imaging,PLLC

14 Raymond Avenue
Poughkeepsie NY 12603

Health Insurance Portability and Accountability Act of 1996

Privacy Policies and Procedures

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received the Notice of Privacy Practice from Medical Diagnostic Imaging.

PATIENT SIGNATURE: X_____ DATE:_____

In lieu of patient signature, I _____, a staff member of Medical Diagnostic Imaging, state that _____ has been given our current Notice of Privacy Practice.

STAFF SIGNATURE: X_____DATE:_____

MEDICAL DIAGNOSTIC IMAGING, PLLC
14 RAYMOND AVENUE
POUGHKEEPSIE, NY 12603
845-471-2848

WAIVER OF LIABILITY

Medical Diagnostic Imaging has advised me that the procedure I am having might not be fully reimbursed by my insurance company, as it might not be considered medically necessary. I have advised Medical Diagnostic Imaging to proceed with the services and I will assume full responsibility for the payment.

I authorize direct payment to Medical Diagnostic Imaging and I am aware that I am responsible for any co-payments, deductible or balance not covered by my insurance carrier.

PROCEDURE: _____

PRINT NAME: _____

SIGNATURE: _____

DATE: _____