DIAGNOSTIC RADIOLOGY INSTITUTE OF KANSAS CITY BILLING FORM

Last Name:________________ MI:_____ First Name:________________ DOB:________
Address:____
City:______________________________ State:__________ Zip:________________
Phone Number:(____)_______________ Cell Number: (____)_______________
SSN# ____________________________ Sex: M F Marital Status: M S D W
Email Address _________________________________

Employment Information:
Employment:________________________________
Address:____
City:______________________________ State:__________ Zip:________________
Work Number: (____)___________ Work Status(circle): Full-Part-Disabled-Retired-Other

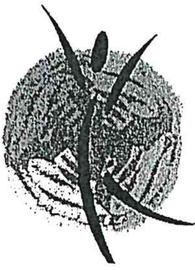
Guarantor Information: (Responsibly Party if NOT Patient)
Last Name:__________________________ First Name:________________ DOB:________
Employer:______________________________________
Address:____
City:______________________________ State:__________ Zip:________________
Employer________________________ Work Number: (____)_______________

Insurance Information:
Self-Pay____ Health Insurance____ Automobile Insurance____ Workers Compensation_____
Date of Injury/Accident:____________________ Claim Number:__________________
Primary Insurance:____ Payor ID#_______________
Billing Address:____
Phone Number: (____)_______________ Contact:____________________
Pre-Cert#_____________ Policy#________________ Group Name:__________________
Insurance Address _________________________________

Accident and Injury Questionnaire:
Is your visit today related to: (Please Circle) Accident Injury Work Comp Other Illness
Date of Accident/Injury___________________ Date of your first symptom:________________
Have you received treatment for this condition before?_________________
If yes, please provide date of last treatment. ___________________
Describe how injury occurred. ____

Patient Signature:____
Date:________

FOR OFFICE USE ONLY:
Medical Record #_______________ NDC: 0019-_________________
CPT Code:_________________ Study:___________________ Addt'l Views:______________



DIAGNOSTIC RADIOLOGY INSTITUTE

"Image Does Matter"

6444 Metcalf • Overland Park, KS 66202 • 913.831.0509 • Fax 913.831.0439

I have been given the option to review/receive a copy of my patient Bill of Rights and/or the HIPPA privacy practice materials.

I have opted to:

______ decline copy of above documents

______ accept copy of above documents

Patient Signature ________________________________ Date: ___________

If you are having CONTRAST today you are being given a DOTAREM medication guide.

Patient Signature ________________________________ Date: __________

CD – Images of the exam I had today!

It is your responsibility to take this CD to your doctor! Your doctor can download the CD into their computer and then give it back to you for your record!

You are responsible for this CD! **ALWAYS TAKE IT WITH YOU, unless otherwise instructed by your doctor; always leave with the CD!**

This CD has the images only; the REPORT will be faxed to your doctor once it has been read by our radiologist!

There is a $25.00 charge for duplication of your CD!

______ **I understand the above!**

Patient signature **Date**

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PATIENT NAME:______________________________________ DATE:________________

MRI XRAY Body part:_______________________________________

PAIN/SYMPTOMS:

____

____

____

How long have you had the symptoms?_____________________________________

Have you had surgery on this area? YES NO When?______________________

Type of injury: (Please circle) MOTOR-VEHICLE ACCIDENT / WORK COMP / OTHER

DATE OF INJURY:____

For spine evaluation: (Please circle all that apply)

NECK PAIN	UPPER BACK PAIN		LOWER BACK PAIN
RIGHT ARM / LEFT ARM	PAIN	NUMBNESS	WEAKNESS
RIGHT LEG / LEFT LEG	PAIN	NUMBNESS	WEAKNESS

ANY BOWEL OR BLADDER CHANGES? ____

For joint evaluation: (Please circle all that apply) Right / Left

SWELLING POPPING LOCKING DISLOCATION FRACTURE INSTABILITY

LOSS OF GRIP STRENGTH DECREASED RANGE OF MOTION

DATE OF YOUR NEXT DOCTOR'S APPOINTMENT________________________________

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BRAIN EVALUATION

PATIENT NAME:____DATE:________________

MRI: IAC ORBITS PITUITARY **MRA:** COW CAROTID **CONTRAST:** YES NO

PAIN/SYMPTOMS:

____

____

How long have you had the symptoms?____

Have you had surgery on your brain including SINUSES? YES NO When?____________

Type of injury: (Please circle) MOTOR-VEHICLE ACCIDENT / WORK COMP / OTHER

DATE OF INJURY:____

Please circle ALL that apply:			>3 Months	<3 Months	Frequency
Headaches/Migraines			CHRONIC	NEW ONSET	____________
Vision Problems	RIGHT	LEFT	CHRONIC	NEW ONSET	____________
Hearing Problems	RIGHT	LEFT	CHRONIC	NEW ONSET	____________
Ringing in ears	RIGHT	LEFT	CHRONIC	NEW ONSET	____________
Weakness/Fatigue			CHRONIC	NEW ONSET	
Dizziness/Difficulty with Balance			CHRONIC	NEW ONSET	
Difficulty Thinking/Remembering			CHRONIC	NEW ONSET	
Speech Problems/Finding Words			CHRONIC	NEW ONSET	
Seizures/Epilepsy			CHRONIC	NEW ONSET	

Do you have a history of **(circle ALL that apply)**:

CANCER / BRAIN TUMOR / STROKE / ANEURYSM / CONCUSSION When? ___________

MRI HISTORY AND SCREENING

Name: ______________________________ Date: ____________

Sex: M F Age: _______ Weight: ________ Previous Patient: Yes No

Please list any medications you are taking

____

Please list **ALL** surgeries you have had **in your life time**:

____

Screening History: (Please check all that apply and explain)

___ Have you had any surgeries in the last 3 months? **Including endoscopy/colonoscopy** — If so, what and when? ____________ Any metal or clips placed? ____________

___ Any surgery involving your brain, heart, or spine? — If so, what ____________

___ Have you ever had cancer? — If so, what kind ____________

___ Allergies to medications, food, contrast, or latex? — Please list ____________

___ Any body piercings, tattoos or tattooed makeup? Magnetic eyelashes/makeup/nailpolish? — If so, where ____________

___ Any medical problems or diseases? — If so, what ____________

Do you have: (please circle) Asthma, HIV, Hepatitis, or on Dialysis

For contrast injections: (please circle all that apply) kidney problems liver problems diabetes I or II

Do you have any of these in your body? (please circle Y or N on ALL)

Y	N	Cardiac pacemaker or defibrillator (ICD)	Y	N	Inner ear implant/ implanted hearing aid
Y	N	Aneurysm clips or brain clips	Y	N	Insulin Pump/Drug infusion device
Y	N	Electronic implant or device	Y	N	Orbital Prosthesis (artificial eye)
Y	N	Heart valve, Stents, Shunts	Y	N	Dentures/Permanent Retainers
Y	N	Magnetically-activated implant or device	Y	N	Any Joint Replacement or Artificial Limb
Y	N	Electrodes or Neuro/Spinal cord stimulator	Y	N	Medication Patch
Y	N	Surgical staples/clips/pins/screws/plates	Y	N	Any bullets or shrapnel
Y	N	Hearing aids **(please remove)**	Y	N	Do you do any welding or grinding
Y	N	Acupuncture needles	Y	N	Metal removed from eyes by doctor

Any devices/implants we should know about before performing this procedure?

____

For Women Only: (please circle)
Are you pregnant or is there a possibility? Y N Breastfeeding Y N IUD (Intrauterine device) Y N ____________

Signature of Person Completing this Form: ______________________________

FOR OFFICE USE ONLY:
Technologist Signature: ____________ Amount of Contrast ____________
Contrast Exp Date: ____________ Lot #: ____________ Injection Site: ____________
Notes:

____

Radiologist Signature (if needed): ____________ Date: ____________

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Notice of Privacy Practices- Revised Effective 12-09-2009

The full extent of our privacy practices are pursuant to the Health Information and Privacy act (HIPPA) of 1996.

Our pledge to you: We understand that healthcare information about you is personal and we are committed to protecting information about you. We create a medical and demographic record of the care and services you receive to provide quality care and to comply with legal requirements. This notice applies to all of the records of your care generated buy our facility, information generated from other healthcare providers, referral sources, insurance companies, case managers and legal services.

Diagnostic Radiology Institute of Kansas City, INC (DRI OF KC) is federally and state mandated to maintain the privacy of your healthcare information. We are required to abide by the terms of this notice. The medical information we record and maintain is known as Protected Health Information, or PHI. We will not use or disclose your PHI without your permission (either verbally or in writing), except as described in this notice.

Your Rights:

1. Request and be provided a copy of your record within 30 days of the follow up visit with your referring physician.
2. Correct your medical record.
3. Request confidential communication.
4. Provide us with a list of those with whom your information may be shared.
5. Ask us to limit the information we share.
6. Get a copy of this privacy notice.
7. Choose someone to act for you.
8. File a complaint if you believe your privacy rights have been violated.

Our uses and disclosures:

1. We may use your information and share as we: treat you, bill for services, consult with referring physicians and case managers, help with public health and safety issues, avert a serious threat to health or safety.
2. Comply with applicable law
3. Address workers' compensation, law enforcement and other government requests.
4. Respond to lawsuits and legal actions.