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MEDICAL IMAGING

PATIENT DEMOGRAPHICS

Name (LAST) _____ (MI) _____ (FIRST) _____

Date of Birth _____ SSN _____

Mailing Address _____

City State Zip

Primary Phone# ( ) _____ Secondary# ( ) _____

○ Home ○ Work ○ Cell ○ Home ○ Work ○ Cell

Email Address: _____

Emergency Contact Name: _____ Number: _____

Primary Insurance: _____

Secondary/Supplemental Insurance: _____

GUARANTOR/RESPONSIBLE PARENT

○ **Same as Above**

Name (LAST) _____ (MI) _____ (FIRST) _____

Date of Birth _____ SSN _____

Relationship to Patient:_____

Primary Phone#( ) _____

Mailing Address (If different from above)_____

City State Zip

DON'T FORGET TO TURN THE PAGE

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Innovative Medical Imaging Privacy Statement/Financial Commitment

INNOVATIVE MEDICAL IMAGING is committed to protecting the privacy of your personal and health information. At INNOVATIVE MEDICAL IMAGING, we understand that health is a very personal, private subject, and we want you to feel as comfortable as possible visiting our imaging center and using its services. INNOVATIVE MEDICAL IMAGING takes this responsibility very seriously.

OUR USES AND DISCLOSURES

INNOVATIVE MEDICAL IMAGING is required to **(1) maintain the privacy and security of your protected health information (2) Let you know promptly if a breach occurs that may have compromised the privacy or security of your information (3) Follow the duties and privacy practices described in this notice and give you a copy of it (4) Not use or share your information other than as described here unless you tell us we can in writing. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

INNOVATIVE MEDICAL IMAGING will collect information that identifies you ("personal information") only when you voluntarily provide it to us through your physician. For example, your physician may ask you to provide some personal information, such as your first and last name, mailing address, telephone number and/or e-mail address. We may use your personal information within INNOVATIVE MEDICAL IMAGING (1) to provide you with the services and products you request, (2) to assist with your questions about our services, billing, and payment methods, (3) to process or collect payments made in connection with our services to you, (4) use and share your health information to run our practice, improve your care, and contact you when necessary, (7) Comply with the law if state or federal laws require it (10) To address workman's compensation claims, law enforcement purposes, health oversite agencies for activities authorized by law, and special gov functions such as military, national security, and presidential protective services, (11) In response to a court or administrative order or in response to a subpoena.

YOUR RIGHTS

INNOVATIVE MEDICAL IMAGING is required to allow you: (1) An electronic copy of your medical record/report. This does not include disc of images, but disc is available for a $5 purchase outside of a physician request. Discs are transferred to referral physicians for the purpose of continuum of care for free (2) to ask us to correct your medical record/We may say no to your request, but we will tell you why in writing within 60 days (3) Request confidential communications such as asking us to contact you in a specific way or to send mail to a different address. We will say yes to all reasonable requests (4) To ask us to limit what we use or share. We are not required to say yes and may say no if it would affect your care (5) Ask for a list of the times we've shared your health information for six years prior to the date you ask, who we shared it with and why (6) 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 (7) File a complaint if you feel we have violated your rights. You may also file a

complaint with the U.S. Dept of Health and Human Services Office for Civil Rights. We will not retaliate against you for filing a complaint (8) to share information with family, close friends, others involved in your care, share information in a disaster relief situation, if you are unconscious we have the right to share your information if we believe it is in your best interest.

INNOVATIVE MEDICAL IMAGING and its employees are dedicated to obtaining, maintaining, using, and disclosing patient protected health information (PHI) in a manner that protects patient privacy. We will disclose only the minimum amount of your PHI necessary to complete testing ordered by your physician or employer. Your physician or employer may have different notices regarding use and disclosure of your PHI in his/her office.

INNOVATIVE MEDICAL IMAGING will not give, sell, rent, loan or otherwise disclose any personal information to any third party, unless (1) you have authorized us to do so in writing, (2) we are legally required to do so, for example, in response to a subpoena, court order or other legal process, and/or (3) it is necessary to do so in order to protect and defend the rights or property of another.

In addition, we have procedures that limit INNOVATIVE MEDICAL IMAGING employee's access to personal information. Only those employees with a business reason to know have access to such information.

INNOVATIVE MEDICAL IMAGING may change this privacy policy from time to time. We will alert all patients that the policy has been changed by changing the effective date at the bottom of this page. We will always let you know the information we collect, how we use it, and the circumstances under which such information may be disclosed by us.

INNOVATIVE MEDICAL IMAGING is honored to be your healthcare provider. Should you have any questions or concerns, please contact us at the following address:

INNOVATIVE MEDICAL IMAGING
512 Pole Line Rd Twin Falls, ID
Phone 208-735-5555

This Notice is Effective as of August 9, 2021

***You agree to reimburse Innovative Medical Imaging the fees of any collection agency, which will be added to the account at the time it is placed with the agency for collection and may be based on a percentage at a maximum of 25% of the debt, and all reasonable costs and expenses, including reasonable attorney's fees, incurred in such collection efforts.

Patient Signature_____ Date _____

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PATIENT MAMMORAPHY SCREENING FORM

PLEASE PRINT NEW PATIENT ☐ RETURN PATIENT ☐

NAME: _____ Date of Birth: _____

Appt. Date/Time: _____ Exam: Mammography Screening / Diagnostic

Is there a possibility that you could be pregnant? ☐YES ☐NO

Are you taking birth control pills? ☐YES ☐NO How Long? _____

Have you nursed in the last 6 months? ☐YES ☐NO Have you had your ovaries removed? ☐YES ☐NO

Are you taking hormones/estrogen? ☐YES ☐NO How long? _____

Do you have a family history of breast cancer? ☐YES ☐NO

If YES, which family member(s)? _____ Age(s) Diagnosed? _____

Do you have any breast concerns? ☐YES ☐NO

If YES, please explain _____

Do you have a personal history of breast cancer? ☐YES ☐NO

If YES which *treatments* have you completed? _____

Have you ever had any breast surgeries or biopsies? ☐YES ☐NO

If YES, which breast? ☐RT ☐LT ☐BILATERAL Which procedures were done?

_____

Signature_____

Technologist to fill out----------

Previous imaging/comments: