



2302 S. 77 Sunshine Strip, Ste. 101  
Harlingen, TX 78550  
(956) 412-2121 FAX (956) 412-2125

Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
First Middle Last

SSN: \_\_\_\_\_ Sex: Female Male

Address: \_\_\_\_\_  
Street/ P.O. Box City State Zip Code

Marital Status:  Single  Married  Divorced  Widowed

Race:  American/Alaskan Indian  Asian  Black / African American  White / Caucasian  Other

Ethnicity:  Hispanic  Non-Hispanic  Decline Email: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Additional: \_\_\_\_\_

Employer Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Employer Address: \_\_\_\_\_  
Street/ P.O. Box City State Zip Code

Insurance Name: \_\_\_\_\_

Policy ID#: \_\_\_\_\_ Policy Group#: \_\_\_\_\_

Primary CardHolder Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN#: \_\_\_\_\_

\*\* We require a copy of your insurance and valid driver license or TX ID \*\*

Is patient allergic to Iodine:  Yes  No  Unsure

Medical Doctor: \_\_\_\_\_ Phone#: \_\_\_\_\_

Who should we thank for referring you: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

I shall be responsible to pay **BAAXTEN IMAGING CENTER**, for professional services. I realize that insurance is a courtesy and not a guarantee of payment for services. I guarantee payment for services rendered. I hereby authorize payment of medical benefits to the supplier for medical services rendered. I also hereby authorize release of medical records to my insurance company and other medical providers.

**Please note: Radiologist Reading Will Be Billed Separately to Insurance.** \_\_\_\_\_ (Please initial)

Patient Signature

Date



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## **PATIENT CONSENT FORM**

The Department of Health and Human Services has established a "Privacy Rule: to help insure that personal health care information is protected for privacy. The Privacy rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patients we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your healthcare operations, in order to provide health and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment or healthcare operations. These entities are most often not required to obtain patient consent.

You may refuse consent to the use or disclosure of your personal health information, but this must be in writing. Under the law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this for, please ask to speak with our HIPPA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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### **COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS**

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To Our Valued Patients:

The misuse of Personal Health Information (PHI) had been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers, and doctors regarding the Health Insurance Portability and Accountability Act (HIPPA) with particular emphasis on the "Privacy Rule. We strive to achieve that very highest standard of ethics and integrity in performing services for our patients.

It is policy to properly determine appropriate use of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel than an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

**Thank you for being one of our highly valued patients.**



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AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_

DOB: \_\_\_\_\_ SSN#: \_\_\_\_\_

I authorize **BAAXTEN IMAGING CENTER** to release the following medical information to:

Name of person / facility: \_\_\_\_\_

Address: \_\_\_\_\_

Check all films that may be released:

- DXA
- X-Ray
- Mammo
- CT Scan
- Ultrasound
- MRI

This authorization covers patient care given from: \_\_\_\_\_ to \_\_\_\_\_

Purpose for disclosure:

- Medical Care
- Insurance
- Attorney
- Other: \_\_\_\_\_

This authorization shall be valid 120 days from the date of signature. This patient can revoke this authorization in writing at any time prior to the expiration date.

This patient agrees that a photocopy of this authorization may be considered valid.

- Yes
- No

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Witness Signature: \_\_\_\_\_

BAAXTEN IMAGING CENTER

**NOTICE OF PRIVACY  
PRACTICES ACKNOWLEDGEMENT**

**PATIENT NAME:** \_\_\_\_\_

**DATE OF BIRTH:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**SOCIAL SECURITY NUMBER:** \_\_\_\_ - \_\_\_\_ - \_\_\_\_

I acknowledge that Baaxten Imaging Center provided me with a written copy of his / her **Notice of Privacy Practices**.

I also acknowledge that I have been afforded the opportunity to read the Notice of Practices and ask questions.

\_\_\_\_\_  
**Patient Signature**

**DATE:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_