GO IMAGING

PATIENT INFORMATION / FINANCIAL RESPONSIBILITY

Name:_____ SSN: _____
Last First Middle Initial

Date of Birth:_____ Sex*: ☐ M ☐ F Marital Status: ☐ S ☐ M ☐ W ☐ D

Home Phone: (_____)_____ Daytime: (_____)_____ Cell: (_____)_____

Address: _____
Street Address (no PO boxes) City State Zip

_____
Mailing Address City State Zip

Email address: _____
(Your email will not be sold or given to any third parties. It will only be used internally.)

Employer: _____ Employment Status (circle): ☐ FT ☐ PT ☐ Retired ☐ Not Employed
Company Name

Emergency Contact: _____
Name Relationship Phone

How did you hear about us? ☐ Physician Referral ☐ Returning Patient ☐ Internet ☐ Word of Mouth ☐ Other

Were you injured? ☐ Y ☐ N **Is this injury work related?** ☐ **Y** ☐ **N** Are you filing a workers compensation claim? ☐ Y ☐ N

Do you reside in a Skilled Nursing Facility? ☐ Y ☐ N Name & Phone of SNF:_____

INSURANCE- Check all insurances you have: ☐ Medicare ☐ Medicaid ☐ PPO ☐ HMO ☐ LOP ☐ Work Comp ☐ Other

Primary Insurance:_____ Policy Holder:_____
Last First MI

SSN of Policy Holder:_____ Policy Holder's DOB: _____

Policy ID Number:_____ Group Number: _____

Patient's Relationship to Policy Holder (please check): ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Policy Holder's Employer:_____ Work Phone: _____

If you do not have a secondary insurance, please write "none."

Secondary Insurance:_____ Policy Holder:_____
Last First MI

SSN of Policy Holder:_____ Policy Holder's DOB: _____

Policy ID Number:_____ Group Number: _____

Patient's Relationship to Policy Holder (please check): ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Policy Holder's Employer:_____ Work Phone: _____

Which method of payment will be used for today's visit? ☐ Visa ☐ Mastercard ☐ AMEX ☐ Cash ☐ Check

For Patients under 18, the Parent/Guardian accompanying minor must provide the information below and sign as the guarantor.

Guarantor:_____ SSN: _____

DOB:_____ Phone:_____ Relationship to Patient: _____

Address: _____

I hereby certify that the above information is true and accurate to the best of my knowledge and JK Radiant, L.P. dba GO Imaging may rely on this information to provide these services. I assign and authorize that payment of these medical benefits be made directly to GO Imaging. I further authorize GO Imaging to release to my insurance carrier information pertaining to my examination and treatment. I understand that I am financially responsible for any charges not covered by my insurance carrier and a $25 fee per returned check cost of collection, if necessary. I understand if payment is not made by my insurance company and/or if I fail to comply with my payment arrangements, my credit report information may be obtained. By listing the information above, I am allowing GO Imaging to contact me via any of the methods I have provided.

Signature of Responsible Party: _____ **Date:** _____

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ULTRASOUND TECH SHEET

Name: _____ DOB: _____
Last First MI

Age: _____ Sex: ☐ Male ☐ Female Weight: _____ Height: _____

Did you eat anything today? ☐ Yes ☐ No If yes, what time? _____

Reason For Exam: ☐ **Mass/lump/nodule** ☐ **Fever** How long have you had this problem? _____

Is this an injury? ☐ Yes ☐ No If so, date of Injury: _____

Medical History: ☐ Kidney Disease ☐ Cancer (type): _____ Approx. Diagnosis Date: _____

Any previous ultrasounds of the body part being examined today? ☐ Yes ☐ No

Where: _____ When: _____

List all previous surgeries: _____

List other medical problems: _____

List all medications presently taking: _____

_____ _____
Signature (***If patient is under 18 years of age, guardian must sign***) Date

Front Desk Use

Patient ID: _____ Exam ordered: _____

ICD-10: _____ Description: _____

CD requested: Y or N If yes, request given to radiology? _____ (initial)

Technologist Use

Patient interview: Why is patient having exam? Explain symptoms in detail.

_____

☐	Abdomen complete	76700	☐	Abdominal & Pelvis Duplex	93975
☐	Abdomen limited (gallbladder/liver)	76705	☐	Aorta Duplex	93978
☐	Abdominal Aorta	76706	☐	Carotid Duplex	93880
☐	Aorta/Renal Retroperitoneal complete	76770	☐	LE Arterial Duplex bilateral	93925
☐	Head & Neck Soft Tissue (thyroid)	76536	☐	LE Arterial Duplex unilateral	93926
☐	Breast ☐unilateral ☐bilateral	76641	☐	UE Arterial Duplex bilateral	93930
☐	Testicular (with or w/o Doppler)	76870	☐	UE Arterial Duplex unilateral	93931
☐	Pelvis Complete Transvaginal	76830	☐	UE / LE Venous Duplex bilateral	93970
☐	Pelvis Complete Transabdominal	76856	☐	UE / LE Venous Duplex unilateral	93971
☐	Soft Tissue Extremity complete	76881	☐	Other: _____	
☐	Soft Tissue Extremity limited	76882			

GO IMAGING

Authorization for Use or Disclosure of Information

I, _____, hereby authorize ***JK Radiant, L.P. dba GO Imaging*** (hereafter ***GO Imaging***) to: (*Please check one or both of the following:)*

_____use and disclose the following protected health information to any physician that can reasonably identify me by name, date of birth and social security number and, and/or

_____use and disclose the following protected health information to:
(Please indicate below to whom we may release information. Please include the names of family members and/or friends.)

_____

(*Please check off what type of information you would allow us to release.*)
_____all medical records _____all billing records

This protected health information is being used or disclosed for the following purpose: To diagnose and/or treat the patient and/or: [List specific purposes here:] _____.

This authorization shall be in force and effect **indefinitely**; I understand that an expiration date may be applied at the time of service and/or that I have the right to revoke this authorization, in writing, at any time by sending such written notification to **notices@go-imaging.com.** I understand that a revocation is not effective to the extent that ***GO Imaging*** has relied on the use or disclosure of the protected health information. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. ***GO Imaging*** will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to:

- Inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights.)
- Refuse to sign this authorization.

[The use or disclosure requested under this authorization will result in direct or indirect remuneration to ***GO Imaging*** from a third party.] [if applicable.]

_____ _____
Signature of Patient or Personal Representative Name of Patient or Personal Representative

_____ _____
Date Description of Personal Representative's Authority

Consent for Purposes of Testing, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by ***JK Radiant, L.P. dba GO Imaging*** (hereafter ***GO Imaging***) for the purpose of providing services to me, obtaining payment for my health care bills or to conduct health care operations of ***GO Imaging***. I understand that service provided to me by ***GO Imaging*** may be conditioned upon my consent as evidence by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out services, payment or healthcare operations of the facility. ***GO Imaging*** is not required to agree to the restrictions that I may request. However, if ***GO Imaging*** agrees to a restriction that I request, the restriction is binding on ***GO Imaging***. I have the right to revoke this consent, in writing, at any time, except to the extent that ***GO Imaging*** has taken action in reliance on this consent.

I understand I have a right to review ***GO Imaging*** Notice of Privacy Practices prior to signing this document and that it is available upon request. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my test, the payment of my bills or in the performance of health care operations. ***GO Imaging*** reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail.

As a courtesy, our facility will file your claim to your insurance company. However, since there is no guarantee of payment by an insurance company, you will be responsible for payment for services received in our office should the insurance not pay plus the cost of collection, if needed. Should collection proceeding or other legal action become necessary to collect an overdue account, the patient or the patient's Responsible Party, understands that ***GO Imaging*** has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect payment for services rendered. The patient, or the patient's Responsible Party, understands that they are responsible for all costs of collection.

_____ _____
Signature of Patient or Personal Representative Name of Patient or Personal Representative

_____ _____
Date Description of Personal Representative's Authority