



Front Range Preventive Imaging

## Patient Information Form

Today's Date: \_\_\_\_\_

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ MI: \_\_\_\_\_ Marital Status \_\_\_\_\_

Sex: M / F Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_' \_\_\_\_" Weight: \_\_\_\_\_ lbs

SS# \_\_\_\_\_ (THIS IS ONLY USED TO OBTAIN PREVIOUS EXAMS & LABS AS NEEDED)

Ethnicity: (circle one) Asian Black Caucasian Hispanic Other

**To better serve and communicate with you more relevantly we would appreciate your email address.  
We keep our email list strictly confidential!**

E-mail address: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ Apt / Suite: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Employer \_\_\_\_\_ Work #: (\_\_\_\_) \_\_\_\_\_

Emergency Contact \_\_\_\_\_ PHONE# \_\_\_\_\_

DO YOU HAVE A HISTORY OF CANCER YES NO WHAT KIND: \_\_\_\_\_

HAVE YOU HAD A PREVIOUS HEART SCAN (CIRCLE ONE) YES NO WHERE \_\_\_\_\_

HAVE YOU HAD A PREVIOUS CT SCAN OF YOUR CHEST YES NO WHERE \_\_\_\_\_

HAVE YOU HAD A PREVIOUS X-RAY OF YOUR CHEST YES NO WHERE \_\_\_\_\_

How did you hear about us: Physician Friend Radio Newspaper

Website Newsletter APP Other \_\_\_\_\_

## Heart Scan

**Medical History:**

**Cholesterol**    High    Low    Normal    Unknown  
 (circle one)

List your cholesterol medications: \_\_\_\_\_

**Smoking**                      No              Current              Former  
 If you smoke: Packs/ day \_\_\_\_\_ Years smoking \_\_\_\_\_

**Blood Pressure**    High    Normal    Low    If high, number of years: \_\_\_\_\_  
 (Circle one)

List your blood pressure medications: \_\_\_\_\_

Diabetes	No	Yes	If yes:	Oral medication	Insulin
Chest Pain	No	Yes			
Chest Tightness	No	Yes			
Chest Pressure	No	Yes			
Unusual Cough	No	Yes			
Fatigue/Dizziness	No	Yes			
Shortness of Breath	No	Yes			
Heart Burn	No	Yes			
Abnormal EKG	No	Yes			
Frequent Palpitations	No	Yes			
Fainting	No	Yes			

Heart Disease                      No              Yes    If yes, describe: \_\_\_\_\_

Are you currently experiencing any of the above symptoms? If yes, please describe:

\_\_\_\_\_

\_\_\_\_\_

**NAME** \_\_\_\_\_ **DATE** \_\_\_\_\_

**Family History: IF YES LIST RELATIONSHIP TO YOU ie: mother,father,etc.**

Stroke	No	Yes	_____
High Blood Pressure	No	Yes	_____
Diabetes	No	Yes	_____
Heart Disease before 55	No	Yes	_____
Heart Disease after 55	No	Yes	_____

- THIS IS NOT YOUR HISTORY BUT FAMILY HISTORY! PLEASE INDICATE ONLY FATHER/MOTHER; BROTHER/SISTER; GRANDPARENTS!

**Past Coronary/Cardiac Procedures: Circle all that apply**

CABG      Angiography      PTCA      Coronary Stent      Other: \_\_\_\_\_

**Miscellaneous Information**

Current level of exercise (circle one)

- Unable to qualify
- None
- Less than 30min. 2-3 times/week
- 30-45min 2-3 times/week
- 45-60min 2-3 times/week
- More than 60min 2-3 times/week

Current level of stress (circle one)

- Unable to quantify
- Low
- Average
- Above average
- High
- Very high

**Current Medications:**

Daily Aspirin	No	Yes
Antioxidants	No	Yes

**Allergies to Medications: Please list medicine and reaction**

\_\_\_\_\_  
\_\_\_\_\_

**NAME** \_\_\_\_\_ **DATE** \_\_\_\_\_



## EBCT Screening Disclosure and Consent

I voluntarily consent and authorize Front Range Preventive Imaging physicians, technologists, and Medical assistants to administer the testing required to perform the EBCT Ultrafast Cardiac screening test.

**IF YOU ARE CURRENTLY EXPERIENCING CHEST SYMPTOMS: PAIN, SHORTNESS OF BREATH, ETC : YOU MUST PROVIDE US WITH A PHYSICIAN'S NAME TODAY**

I realize that there is a small amount of radiation exposure associated with the EBCT procedure. I further understand that although this screening can help identify certain early disease states, it should not be considered a substitute for a thorough examination or other testing recommended by a physician. Like all diagnostic tests, a normal scan does not guarantee that I will not have a heart attack or need treatment for coronary disease.

I understand that the EBCT Ultrafast examination is intended as a screening tool and the possibility exists that abnormalities may be found. If such abnormalities are found, I understand that other testing and/or diagnostic procedures may be needed to further evaluate the findings. I do understand that such tests and/or procedures may entail additional costs for which I am responsible. **I understand that Front Range Preventive Imaging is not responsible for my follow-up medical care. My results will be made available to the physician of my choice.**

I have been given an opportunity to ask questions about this procedure and the risks and hazards involved and I believe that I have sufficient information to give this informed consent. I certify that I have read this form and I understand its contents.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Signature Date

The report for any of the above procedures contains medical terminology that is likely to require interpretation by a physician.

I hereby consent that Front Range Preventive Imaging may send a copy of the medical report for this procedure to my physician. I will receive a copy of the report also.

\_\_\_\_\_  
Physician's Name

\_\_\_\_\_  
Physician's Address

\_\_\_\_\_(\_\_\_\_)\_\_\_\_\_  
Physician's City State Zip Phone

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Patient Signature Date



# Front Range Preventive Imaging

## Policy Regarding Messages

In an effort to protect your privacy, we have developed a policy on leaving medical care messages.

We will NOT leave messages with anyone except the patient or legal guardian.

We will NOT leave any information on an answering machine / voice mail.

**UNLESS**

we have your written permission to do so.

Please read below and consider carefully whom you want to have access to your medical information.

I, \_\_\_\_\_, give Front Range Preventive Imaging my permission to leave phone messages regarding my medical care and information as listed below. I fully understand that this authorization will remain valid until revoked in writing.

My home / mobile answering machine / voice mail: Phone: (\_\_\_\_\_)\_\_\_\_\_

My office / work voice mail: Phone: (\_\_\_\_\_)\_\_\_\_\_

My spouse: Name \_\_\_\_\_ Phone: (\_\_\_\_\_)\_\_\_\_\_

Other: Name \_\_\_\_\_ Phone: (\_\_\_\_\_)\_\_\_\_\_

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Patient Signature Date

## Financial Policy

We are committed to providing you with the best possible care, and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship.

We must emphasize that as health care providers, our relationship is with you, not your insurance company. Any benefits quoted to you are NOT a guarantee of payment from the insurance company.

- Your insurance is a contract between you, your employer, and the insurance company.
- Patients covered under a PPO / HMO plans are responsible for complying with the PPO / HMO rules, regarding written and phone referrals from primary care physicians, if that is a requirement of your plan.
- Failure to comply with the referral requirements of your plan will make it necessary for us to bill you directly for charges incurred during a non-referred visits.
- We will process claims with PPO /HMO plans with which we have a contract agreement, according to that agreement.
- Required co-payments, if applicable, should be made on the day services are provided. You are responsible for all co pays, deductibles, coinsurance, and amounts not covered by your Ins. Co. You will be billed for any balance on your account after the Ins. has paid their portion.

**Payment for service is due at the time service is rendered.** You are responsible for timely payment of your account, and for any balance remaining after insurance payment has been received. There will be a \$25.00 charge for all checks returned for insufficient funds.

I have read the above information; I understand and agree that I am responsible for payment of services rendered.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Patient Signature Date



## Notice of Health Information Practices

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

### Introduction

At Boulder Internal Medicine and Front Range Preventive Imaging, we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice applies to all protected health information as defined by federal regulations.

### Your Health Information Rights

Although your health record is the physical property of Boulder Internal Medicine and Front Range Preventive Imaging, the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request,
- Inspect and copy your health record (**a reasonable fee will be required**),
- Request an amendment of the health record,
- Obtain a list of the disclosures of the health information,
- Request restrictions on certain uses and disclosures of your information, and
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

### Our Responsibilities

Boulder Internal Medicine and Front Range Preventive Imaging is required to:

- Maintain the privacy of the health information,
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and

maintain,

- Abide by the terms of this notice, and
- Notify you if we are unable to agree to a requested restriction.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will provide the updated policy at the time of a future visit or you may obtain a copy of the revised notice by stopping by our facility.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or to disclose your health information after we have received a written revocation of the authorization.

**We will provide health information without authorization when necessary to provide you with treatment, to receive payment or prior authorizations from third parties, and for healthcare operations.**

*Business associates:* There are some services provided by or for Boulder Internal Medicine and Front Range Preventive Imaging through contacts with business associates. Examples may include physician services in the emergency

department and radiology, certain laboratory tests, and a transcription service. When these services are used, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. We require our business associates to appropriately safeguard your information.

*Communication with family:* As health professionals, using our best judgment, we may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

*Contacts:* We may contact you to provide appointment or follow-up reminders, information about treatment alternatives, or other health related benefits and services that may be of interest to you.

*Funeral directors:* We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

*Research:* We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

*Food and Drug Administration (FDA):* We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

*Workers compensation:* We may disclose health information about you for worker's compensation or similar programs, which provide benefits for work related injuries or illness.

*Public health:* As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

*Correctional institution:* Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.

*Law enforcement:* We may disclose health information for law enforcement purposes as required by law in specific circumstances, for military or national security purposes, in response to valid judicial or administrative orders, or to avoid a serious health threat.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, or the public.

**I have received and read this Notice of Health Information Practices. I fully understand this Notice and have had all my questions answered.**

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Print Name

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Signature

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Date

### **For More Information or to Report a Problem**

If you want additional information or if you believe your privacy rights have been violated, you can file a complaint with Boulder Internal Medicine and Front Range Preventive Imaging or contact the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint. The address for the Office for Civil Rights is listed below:

U.S. Department of Health and Human Services  
200 Independence Avenue, S.W.  
Room 509F, HHH Building  
Washington, D.C. 20201