COASTAL RADIOLOGY/GREENSBORO RADIOLOGY

Patient Registration Form (PLEASE PRINT CLEARLY)

Patient's Name: **Date of Birth:**

SSN#:_____ **Gender:** □ Male □ Female **Language:** ❑ English ❑ Spanish ❑ Other: _____

Race: ❑ American Indian or Alaska Native ❑ Asian ❑ Black or African American ❑ Native Hawaiian or Other Pacific Islander ❑ Other ❑ Unknown ❑ White ❑ Decline to Answer

Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ Decline

Mailing Address: _____City: _____State: _____Zip:_____

Home Phone: _____Cell Phone: _____Work Phone: _____

Occupation: _____Employer: _____

E-mail: _____How Did You Hear About Us?:_____

Pharmacy Name**:** _____ Pharmacy Number: _____

Primary Physician: First Name: _____ Last Name: _____

Referring Physician: First Name: _____ Last Name: _____

Responsible Party's Name (If Different from Patient): _____
First Middle Last

SSN#:_____ Date of Birth: _____

Street Address: _____City: _____State: _____Zip:_____

Home Phone: _____Cell Phone: _____Work Phone: _____

Employer: _____ Relationship to Patient: _____

Primary Insurance Holder: _____Primary Company: _____

Secondary Insurance Holder: _____Secondary Company: _____

In case of emergency, contact : _____ Relationship to Patient:_____

Home Phone: _____Cell Phone: _____Work Phone: _____

BILLING POLICY: I understand that I will be billed for any amounts due by me (co-payments/co-insurances/deductibles) and that I have a financial responsibility to pay these amounts. I understand that I will be provided with one (1) statement for any balance due after insurance has processed my charges. I further understand that if I / in my account being sent to an outside collection service for further actions. I also understand that I will be responsible for any collection, interest or legal expenses associated with these collection efforts.

- **We are an affiliation of Greensboro Radiology. Greensboro Radiology processes all billing and payments.**
- I hereby authorize the payment of medical benefits to Coastal Radiology/Greensboro Radiology for services rendered. I understand that I am financially responsible for any services not covered by my insurance carrier.
- I hereby authorize Coastal Radiology/Greensboro Radiology to release any medical information necessary to complete and process my insurance claims.
- I consent to receive **phone calls** from or on behalf of Coastal Radiology/Greensboro Radiology, including those using automated dialing systems and/or an artificial or prerecorded voice, which may include, but are not limited to, payment-related communications and messages.
- I consent to receive **text messaging and/or emails** from or on behalf of Coastal Radiology/Greensboro Radiology, which may include, but not limited to, payment-related communications and messages. I can follow the prompts to view and pay my statement or opt out of text messaging/email by replying "STOP" to the text or "Unsubscribe" to the email (which will queue a paper statement.

_____ I authorize physicians at Coastal Radiology/Greensboro Radiology to treat me and use my personal health information for healthcare operations.

_____ _____

Patient's Signature (If patient is a MINOR, must have Responsible Party Signature) Date

COASTAL RADIOLOGY/GREENSBORO RADIOLOGY

RADIOLOGY PARTNERS

HIPAA AUTHORIZATION FORM

Patient Name: DOB: Acct/MRN:

1. Patient Preferred Communications:
I prefer to receive lab/radiology results, billing/financial, future appointment reminders and other matters as they relate to treatment, payment and healthcare operations to:

(1) Home Number: _____
(2) Work Number: _____
(3) Cell Number: _____
(4) Other: _____
(5) Email: _____

Unencrypted Email and Text Message Communications:
It is Coastal Radiology/Greensboro Radiology policy to send encrypted/secure email. By checking the boxes below, you are authorizing Coastal Radiology/Greensboro Radiology to send email and/or text messages in an unencrypted format. Information sent in an unencrypted manner increases the risk of unauthorized access and disclosure.

□ I would like to receive unencrypted email. Email Address: _____ for:
□ Appointment Reminders □ Breach Notification □ Billing/Financial □ Medical

□ I would like to receive unencrypted text messages. Text Number: _____for:

□ Billing/Financial

2. Personal Representatives: A Personal Representative has the authority to make healthcare decisions on your behalf. Please list any Personal Representatives:

Name: _____ Name: _____

Address: _____ Address: _____

_____ _____

Name: _____ Name: _____

Address: _____ Address: _____

_____ _____

3. Uses and Disclosures:

I, _____, authorize Coastal Radiology/Greensboro Radiology to disclose my health information to the Personal Representatives, if any, listed above. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

4. Requested Restrictions: (You have a right to request restrictions on specific uses and disclosures of protected PHI, as well as to request confidential communications in certain circumstances). Please list below:

_____
_____
_____
_____
_____

5. Authorization Statements/Signatures:

1. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to a staff member. I understand that the revocation will not apply to information that has already been released in response to this authorization.

2. Unless I specify differently below, this authorization will remain in effect until revoked by me.
   I would like to this authorization to expire: _____

3. I understand that Coastal Radiology/Greensboro Radiology will not condition the provision of treatment or payment on the provision of this authorization.

_____ _____
Signature of Patient or Personal Representative Date

_____
Print Name

_____
Personal Representative's Title (e.g., Guardian, Executor of Estate, Health Care Power of Attorney

_____

Office Use Only

_____

Revocation

Date Revoked: _____

Initials of Privacy Officer: _____

Coastal Radiology/Greensboro Radiology
RADIOLOGY PARTNERS

Patient Questionnaire

Patient Name: **DOB:** **DATE OF SERVICE:**
Height: _____ Weight: _____lbs

1. Have you had a Flu Vaccine this year? YES NO

2. Have you ever had a Pneumococcal Vaccine? YES NO

3. Have you ever had a COVID-19 Vaccine? YES NO

   a. If yes, which of the following:

      Moderna Pfizer Johnson & Johnson

   Date Vaccination was Completed: _____

4. Have you ever smoked? YES NO

   a. If yes, do you currently smoke? _____

   b. How many packs per day? _____

   c. If former smoker, what year did you quit? _____

5. Do you use tobacco or vaping products? YES NO

   a. If yes, please indicate use? _____

6. Do you drink alcohol? YES NO How often? _____

7. For patients whose primary diagnosis is back pain, when did your back pain start?
_____

   a. Have you had an x-ray, CT, Bone Scan or MRI of your

      back? _____

   b. If so, when did you have the study? _____

8. For women only, have you had a mammogram within the last two years?

   YES NO

9. For men 60 years and older, have you ever been screened for an abdominal aortic aneurysm? YES NO

10. Do you have any advanced directives for healthcare? □ YES □ NO

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Clinical Assessment Form

Part 1 of 2

DATE:	
PATIENT NAME:	**DATE OF BIRTH:**
PHONE NUMBER:	

***Please take a moment to consider the following questions. If you answer YES, when indicated, please rate how important the response is to your quality of life and activities of daily living.**

How did you hear about us? (Please indicate by circling the letter for the appropriate response)

- Physician Referral: Name of Physician: _____
- Word of Mouth
- Insurance Company

2. Other: _____

Do you have:	**No**	**Yes**	**Less Important To Very Important**				
Pain/Aching/Throbbing?	N	Y	1	2	3	4	5
Night Cramps?	N	Y	1	2	3	4	5
Leg tiredness?	N	Y	1	2	3	4	5
Itching of the skin near or a vein?	N	Y	1	2	3	4	5
Swelling of feet/ankles?	N	Y	1	2	3	4	5
Skin discoloration?	N	Y	1	2	3	4	5
Skin rash or eczema?	N	Y	1	2	3	4	5
Sores or ulcers on legs/ankles?	N	Y	1	2	3	4	5
Unsightly appearance of your veins?	N	Y	1	2	3	4	5

If you have pain, please circle most appropriate:
None Occasional Interferes with daily activity Limits daily activity

Do you use over-the-counter pain medication for leg discomfort?
No Yes (If YES, specify type of medication _____

If you have swelling, please circle most appropriate: None Foot/Ankle Below Knee Above Knee

Do you use compression stockings?
No Yes (If YES, specify type of stocking _____ duration of use _____)
(Circle most appropriate: None Intermittent Most Days Fully Comply)

What makes the symptoms better?
Rest Elevation Stockings Massaging Walking Changing Positions

What makes the symptoms worse?
Standing Menstrual Cycle Walking/Exercise Prolonged Sitting

Did you notice a change in your veins following? (Circle)
Leg Injury Pregnancy Medication Surgery Blood clot in leg

Describe the veins in your legs (Circle)
Rope-like spider veins Blue/Lines knots

DATE:	
PATIENT NAME:	**DATE OF BIRTH:**
PHONE NUMBER:	

Have you ever had any of the following problems related to your leg veins?

Clot in leg vein (DVT)?	N	Y	Inflammation of vein ("Phlebitis")?	N	Y
Clot in your lung (Pulmonary Embolism)?	N	Y	Venous related ulcers?	N	Y
Spontaneous rupture of vein?	N	Y			

Do you have a family history of (circle):

4. Varicose vein problems C. Blood clots (DVT or Pulmonary Embolus)
5. Phlebitis D. Leg ulcer

Have you ever had any of the following medical problems?

Clotting disorder?	N	Y	Asthma?	N	Y
Need for blood thinner medication?	N	Y	Stroke?	N	Y
Leg trauma?	N	Y	Heart problems?	N	Y
Obesity?	N	Y	Aneurysm?	N	Y
Malignancy?	N	Y	Artery disease legs?	N	Y
Major trauma?	N	Y	Tobacco use?	N	Y
Prolonged immobility (any reason)?	N	Y	Diabetes?	N	Y
Easy bruising?	N	Y	Seizures?	N	Y
Thrombocytopenia?	N	Y	Fainting/dizziness?	N	Y
High blood pressure?	N	Y	Hives?	N	Y
Autoimmune disease?	N	Y	Hepatitis?	N	Y

Do you work? No Yes (If YES, specify type of work_____)

Does your work require:

b. Prolonged standing position N Y
c. Prolonged sitting position N Y

In the course of a normal day, how much time is spent in a standing position during the day?

c. 10% B. 20% to 30% C. 30 to 50% D. More than 50%

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Clinical Assessment Form

Part 2 of 2

DATE:	
PATIENT NAME:	**DATE OF BIRTH:**
PHONE NUMBER:	

Due to the symptoms above; are you limited in any of the following activities?

	No	**Yes**	**Fewer Limitations**		**To**	**Very Limited**	
Work?	N	Y	1	2	3	4	5
Housework routine?	N	Y	1	2	3	4	5
Walking?	N	Y	1	2	3	4	5
Shopping?	N	Y	1	2	3	4	5
Sports or hobbies?	N	Y	1	2	3	4	5
Social Limitations?	N	Y	1	2	3	4	5

Due to social embarrassment, do you limit any of the following activities?

	No	**Yes**	**Fewer Limitations**		**To**	**Very Limited**	
Sport?	N	Y	1	2	3	4	5
Exercise?	N	Y	1	2	3	4	5
Leisure Activities?	N	Y	1	2	3	4	5
Job Changes?	N	Y	1	2	3	4	5
Job Choices?	N	Y	1	2	3	4	5
Do you limit your clothing choices?	N	Y	1	2	3	4	5

Have you had vein evaluations in the past elsewhere?

No Yes (If YES, where? _____when? _____)

Have you had prior procedures or operations on the veins of your legs?

No Yes

(If YES, where? _____when? _____what?_____)

What are your expectations for today's visit?

A. Evaluate leg pain and/or swelling
B. To learn more about my vein problem
C. To learn about surgical options for varicose veins
D. To learn about cosmetic options for varicose veins
E. Other: _____

Do you have any other concerns about your veins that need to be addressed during your visit today?

_____

COASTAL RADIOLOGY/GREENSBORO RADIOLOGY

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, you are acknowledging that you have received a copy of the Notice of Privacy Practices.

_____ _____
Patient's Printed Name DOB

_____ _____
Patient's or Authorized Personal Representative's Signature Date

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Office Staff Use Only

Indicate why a sign acknowledgement could not be obtained:

- The patient refused to sign this form.
- Emergency situation prevented our practice from obtaining the patient's signature.
- The NPP was mailed or emailed to the patient per request.

  Mailing Address_____ Date mailed: _____

  Email Address: _____ Date emailed:_____

- Other Reasons:_____

_____

_____

_____ _____
Employee's Printed Name Employee's Signature

Date: _____

Coastal Radiology Associates / Greensboro Radiology
RADIOLOGY PARTNERS
NON-DISCRIMINATION NOTICE & ACKNOWLEDGEMENT

Discrimination is Against the Law

Coastal Radiology complies with applicable Federal civil rights laws and does not discriminate based on race, color, national origin, age, disability, or sex (consistent with the scope of sex discrimination described at 45 CFR § 92.101(a)(2)). Coastal Radiology Associates does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Coastal Radiology Associates:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formations (large print, audio, accessible electronic formations, etc.)
- Provides free language assistance services to people whose primary language is not English, which may include:
    - Qualified interpreters
    - Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact Stevie Roadman at stevie.roadman@radpartners.com or 252-633-5057x5018.

If you believe Coastal Radiology Associates has failed to provide these services or has discriminated in another way based on race, color, national origin, sex, age, or disability, you can file a grievance with the Compliance Office:

- Email: compliance@radpartners.com
- Compliance Hotline: 844-754-3344 or https://radpartners.mycompliancereport.com/

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Stevie Roadman is available to help you.

You can also file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights:

- Electronically: https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf
- Mail: US Department of Health & Human Services, 200 Independence Ave, SW – 509F, Washington DC, 20201

Visit *www.coastalradiology.com* to review this Non-Discrimination notice online.

By signing below, you are acknowledging that you have read and receive a copy of this Non-Discrimination Notice.

_____ _____

Patient's Printed Name DOB

_____ _____

Signature of Patient/Authorized Representative Date