ALBANY ADVANCED IMAGING, PLLC
3 ATRIUM DRIVE
ALBANY, NEW YORK 12205

Patient Name: _____ Date: ___/___/___

Address: _____
Street City/State Zip Code

DOB: ___/___/___ Soc. Sec. No.: _____-_____-_____ Tel.: (_____) _____-_____

Insurance Guarantor (policyholder): _____ DOB: ___/___/___

Address (if different from above): _____

Patient Insurance Waiver and Notice of Responsibility

As a consumer of medical service, you may have an agreement with an insurance carrier to assist with payment of your medical care. Albany Advanced Imaging, P.L.L.C., maintains agreements with various insurance carriers. Should we participate with your insurance carrier, we are happy to bill your insurance provider directly. Your signature on this form today authorizes us to do so. If your insurance carrier (for whatever reason) chooses not to satisfy your bill in full, you understand and accept complete personal responsibility for any payment due.

Some insurance companies require your doctor to obtain approval before imaging is performed. Albany Advanced Imaging, P.L.L.C. is not responsible for obtaining or justifying pre-certification, authorization or approval. Your signature authorizes Albany Advanced Imaging, P.L.L.C. to perform the examinations(s) requested by your doctor. Albany Advanced Imaging, P.L.L.C. is not responsible in any way should your insurance carrier deny payment for your examination.

Initial Here _____

Receipt of Notice of Privacy Practices ***POSTED ON WALL***

I have been informed of the Notice of Privacy Practices from Albany Advanced Imaging, P.L.L.C. concerning how the use of disclosure of Protected Health Information will be handled by the practice. This notice is posted in the office reception area. I understand I can also receive a copy of this notice.

(Initial here) _____

Signature: _____ Date: ___/___/___

Your relationship to the patient (if applicable) _____

Albany
Advanced Imaging
THE RADIOLOGY SPECIALISTS

Y	*N*	*PLEASE MARK **YES** OR **NO** FOR EACH QUESTION*	***(IF YES, ELABORATE)***
☐	☐	Do you have any allergies or sensitivities?	
☐	☐	Are you or could you be pregnant or breast feeding?	
☐	☐	Have you had anything to eat in the last 8 hours?	
☐	☐	Do you now have or have you ever had cancer? What kind?	
☐	☐	Do you have diabetes?	
☐	☐	Do you take any pain medications (*Percocet, Percodan, Demerol, Tylox, Tylenol#3, Oxycodone, Duragesic (Fentynal) Patch, Methadone*, etc.)	
☐	☐	Do you take thyroid medications? When did you last take it and what is it?	
☐	☐	Do you take any medications to speed up your GI tract (*Reglan / Zelnorm / Domperidone / Erythromyacin*) **WHEN?**	
☐	☐	Do you take any multivitamins or supplements?(*Please list*)	
☐	☐	Do you take other medications? (*Please list*)	
☐	☐	Have you ever broken any bones?	
☐	☐	Have you had surgery on your GI tract **esophagus,stomach,colon**)?	
☐	☐	Have you had other surgeries?	
☐	☐	Have you had any recent traumatic events? **(fall, car accident**)	
☐	☐	Have you recently had any tests(**CT,MRI,US,XRAY,ANGIO**)?	
☐	☐	Have you recently had any blood work? What were the results?	
☐	☐	I understand that if I am pregnant/breast feeding I should notify the front desk immediately.	
☐	☐	I understand that I will be receiving a radiopharmaceutical for this test. I also understand that law enforcement officials have been issued radiation detectors that are sensitive enough to detect low levels of radiation, including radiation from patients who have received diagnostic and/or therapeutic radioactive materials. ☐ *Check here if you would like written documentation to give to law enforcement officials.*	

Your doctor has referred you for this test; what have your symptoms been?(*Circle or write it in any pertinent information*) *Heartburn / Chest Pain / Nausea / Vomiting / Abdominal Pain / Bloating / Distention / Constipation / Diarrhea / Other / back pain / abnormal blood work / abnormal exam*

_____

_____

_____

_____

Height_____ **Weight**_____ **AGE**_____ **Date of birth**_____

SIGNATURE_____ **DATE**_____