



PATIENT INTAKE FORM

PATIENT INFORMATION

MRN: _____

Last Name: _____ First Name: _____ MI: _____ Gender: M / F

Marital Status: Single Married Divorced Widowed DOB: _____ SSN: _____ - _____ - _____

Address: _____ City: _____ State: _____ Zip: _____

Home PH: _____ Mobile/Other: _____ Date of Onset of pain/injury _____

Employment Status: Full Time Part Time Un-Employed Student Disabled Retired Date of Retirement: _____

Employer: _____ Work Phone _____ Ext: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact Name: _____ PH#: _____ Rel to Patient _____

May we send you an email to follow-up on the quality of service we provided today? Y / N Email _____

RESPONSIBLE PARTY (Complete if patient is under age of 18 years)

Name: _____ SSN: _____ - _____ - _____ DOB: _____ Rel to Patient _____

Address (if different from patient): _____

PRIMARY INSURANCE INFORMATION

Ins Co Name: _____ Insured Name: _____ DOB: _____ Rel to Patient _____

Insured Employer: _____ Address: _____ Emp PH#: _____

SECONDARY INSURANCE INFORMATION

Ins Co Name: _____ Insured Name: _____ DOB: _____ Rel to Patient _____

Insured Employer: _____ Address: _____ Emp PH#: _____

ASSIGNMENT OF BENEFITS AND FINANCIAL AGREEMENT

1. I have reviewed the information provided and verify it is accurate.
2. I understand if I have provided complete and accurate insurance information, Outpatient Imaging Associates (OIA) will file both my primary and secondary insurance. I also agree to be responsible for any additional co-share or non paid amounts identified by my insurance after my claim has been processed. In the event legal action should become necessary I agree to be financially responsible for all collection, attorney and court fees incurred.
3. I understand if the services provided today are being represented by an attorney, auto insurance, and or third party payor, I am financially responsible for all charges incurred.
4. I authorize OIA to release to my insurance company any medical information which may be necessary for processing my insurance claim. I also assign "benefits payable to" for my services today to OIA.
5. I further authorize the release of any medical information in regard to the services which are provided by OIA to any physician or health care provider by whom I have been or will be treated who request such information.

Patient/Guardian Signature: _____ Date: _____



3920 North Union Boulevard, Suite 130
Colorado Springs, CO 80907
(719)268-3300

**ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES***

You may refuse to sign this acknowledgement

*Outpatient Imaging Associates will use and disclose your personal health information to treat you,
to receive payment for the care we provide, and for other health care operations.*

Healthcare operations generally include those activities we perform to improve the quality of care.

*We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies about your personal health
information.*

*The terms of the notice may change with time and we will always post the current notice at our facilities, on our website, and have
copies available for distribution.*

I have received a copy of this facility's Notice of Privacy Practices.

Printed Name

Signature

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices but the acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify) _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT
Include completed consent in the patient's Medical Record