

**Dayton Interventional Radiology, LLC**

3075 Governors Place, Dayton, OH 45409

**Patient Registration Form**

**Patient Name** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_ **Age** \_\_\_\_\_ **Social Security Number** \_\_\_\_\_  
 Male ( ) Female ( ) **Marital Status:** Single ( ) Married ( ) Divorced ( ) Widowed ( ) Separated ( )

**Home Address** \_\_\_\_\_ **City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip Code** \_\_\_\_\_

**Home Phone Number** \_\_\_\_\_ **Work Phone Number** \_\_\_\_\_ **Mobile/Cell Phone** \_\_\_\_\_ **Email Address** \_\_\_\_\_

**Emergency Contact Name** \_\_\_\_\_ **Emergency Contact Phone #** \_\_\_\_\_ **Alternate Name and phone #** \_\_\_\_\_

**Legal Guardian/Parent** \_\_\_\_\_ **Phone Number** \_\_\_\_\_ **Social Security Number** \_\_\_\_\_

**Primary Insurance** \_\_\_\_\_ **Secondary Insurance** \_\_\_\_\_ **Other** \_\_\_\_\_

**Is this a Workman's Compensation Claim? Yes No**

We will need a completed and approved C9 form in order to provide services for a workman's compensation claim.

**Policy Holder Name** \_\_\_\_\_ **Social Security #** \_\_\_\_\_ **Relationship to Patient** \_\_\_\_\_ **Policy Number** \_\_\_\_\_ **Group Number** \_\_\_\_\_

**Policy Holder Address** \_\_\_\_\_ **City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip Code** \_\_\_\_\_

**Primary Care Physician** \_\_\_\_\_ **Office Phone** \_\_\_\_\_ **Fax number** \_\_\_\_\_ **Referring Physician** \_\_\_\_\_ **Office Phone#** \_\_\_\_\_ **Fax Number** \_\_\_\_\_

**How did you hear about us?** Radio\_\_ TV Advertisement\_\_ Newspaper\_\_ Yellowpages\_\_ Internet\_\_  
 Family\_\_ Friends\_\_ Physician\_\_ or Other\_\_ (please specify)\_\_\_\_\_

**Patient Disclosure****ASSIGNMENT OF INSURANCE BENEFITS AND NOTICE OF PRIVACY PRACTICES RECEIPT**

The undersigned hereby authorizes the release of any information in relation to all claims, including Medicare for benefit submitted on my behalf and/or my dependants. I further agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits for services rendered or to be rendered, without obtaining my signature on each claim form to be submitted for myself and/or dependants, and that I will be bound by this signature as though the undersigned had personally signed each claim. I hereby authorize my insurance carrier to pay and assign all medical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance and other health plans to Dayton Interventional Radiology, LLC. I authorize the release of any medical records for treatment, payment or healthcare expenditure. I have received and read a copy of the Notice of Privacy Practices and The Financial Policy for Dayton Interventional Radiology. It fully describes how Dayton Interventional Radiology, LLC will use and disclose my health information to carry out my treatment, obtain payment and conduct healthcare operations. I understand that a copy of this notice is posted in the waiting room and that a copy has been made available to me. It is also my understanding that if my claim is a Workman's Compensation claim, every effort will be made to obtain an approved C9 form for services; however an approved C9 is not a guarantee of payment. Therefore, I am aware that I will be personally responsible for the charges for the services provided to me and I agree to pay for these services if payment is rejected by Workman's Compensation within 30 days of the claim being filed. I confirm that the information I provided is complete and accurate to the best of my knowledge. I have read, understand, and hereby consent to the medical care and services provided at this facility. Dr. Mubin Syed is the Medical Director for this facility and is the attending physician supervising your care and the services performed at this facility. The HIPAA Privacy Officer for this facility is Mita Morar, PA-C. For access to your protected health information and to address comments and/or complaints, both the Medical Director and the Privacy Officer may be contacted by calling our office 937-424-2580. In case of an emergency please call 911 or visit the nearest hospital emergency room. This facility does not honor advanced directives in case of emergency. All efforts will be made to protect, secure and save your life in case of an emergency. 911 will be called and CPR initiated. If you should have questions, concerns, comments or complaint regarding staff or services at this facility please call the toll free complaint hotline at the Department. of Health, State of Ohio. 800-342-0553

This agreement/ consent will remain in effect unless revoked by me in writing. I have read and accept the terms as set forth above. A duplicate copy of this statement will be considered the same as the original.

\_\_\_\_\_  
**Patient Signature or Responsible Party Signature**

\_\_\_\_\_  
**Date**

## **Financial Policy for Dayton Interventional Radiology**

***It is the policy of this office that all patients pay the patient owed portion or patient responsible amount at the time of service. This includes co-pays, deductibles and known non-covered services, auto accidents and all services for self pay patients.***

All patients without medical insurance will be eligible for our self pay reduction plan. The reduced amount will be equal to the current Medicare part B fee schedule. All self pay patients are required to pay the entire office visit, at the discounted rate, in full at the time of service. If payment in full at the time of service is not financially possible, a payment plan may be arranged before services are rendered with the billing manager. Balances are encouraged to be paid in full within 90 days. Failure to follow payment arrangements may cause the practice to discharge the patient for failure to meet financial responsibility, and resort to legal collection activity.

For all patients with insurance, all co pays will be collected at the time of service. No payment arrangement will be made for these amounts.

For all balances as a result of deductibles, or co insurance amounts issued by the patients medical insurance, payment is expected to be received in full within thirty (30 days) from the statement date. If this is not financially possible, payment arrangements may be arranged with our billing manager. Balances are encouraged to be paid in full within 90 days. Failure to follow payment arrangements may cause the practice to discharge the patient for failure to meet financial responsibility, and resort to legal collection activity.

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

# Dayton Interventional Radiology, LLC

Mubin Syed, M.D.  
Kamal Morar, M.D.  
Robert Tyrrell, M.D.

3075 Governors Place Blvd.  
Suite 120  
Dayton, Ohio 45309  
937-4242580/ 937-424-2581

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By signing below, I \_\_\_\_\_ confirm and authorize all employees of Dayton Interventional Radiology, LLC to utilize my Personal Health Information to include:

1. I authorize Dayton Interventional Radiology and employees to confirm my appointment:

(Please circle all that apply)

- a. To my self      b. By USPS mail      c. With family member      d. By phone  
e. On voice mail

If you chose B as one of your choices please provide address \_\_\_\_\_

If you chose C as one of your choices please provide names \_\_\_\_\_

2. I authorize Dayton Interventional Radiology and employees to give lab results or any other diagnostic study done (both positive and negative):

(Please circle all that apply)

- a. To my self      b. By USPS mail      c. With family member      d. By phone  
e. On voice mail

If you chose B as one of your choices please provide address \_\_\_\_\_

If you chose C as one of your choices please provide names \_\_\_\_\_

3. I authorize Dayton Interventional Radiology and employees to call in prescriptions to the pharmacy per my request and to give all information requested in order for the pharmacists to fill the prescription the doctor authorizes.      Yes      no

I understand this authorization is valid and will remain in effect until I request otherwise in writing.

\_\_\_\_\_  
Patient Name ( print )

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

# REQUEST FOR RECORDS RELEASE

All requests will be processed within 15 days after receipt of payment. An invoice will be mailed to you for payment. Please notify the office immediately if you would like to pick up your records instead of receiving them in the mail. All requests by physician offices will be processed and mailed/faxed to the stated office name and address and/or fax number.

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

Patient Name: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Send Records to: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Dear Doctor: \_\_\_\_\_:

The following individual has asked us to request his or her medical records be released and forwarded to Dayton Interventional Radiology. In order for us to fully evaluate this patient's health and make informed decisions, the patient has approved our request for all relevant medical records in your file. Please be sure to include x-ray films and reports of labs, diagnostic studies etc... Thank you for expediting this request. Please send these records Dayton Interventional Radiology 3075 Governors Place Blvd. Suite 120, Kettering, Ohio 45409 Fax: 937-424-2581

I hereby request the release of all necessary medical records. I acknowledge/am aware of the processing fees and agree to pay for the copying of the records requested. Additional fees for postage and handling, films images, copies of disc with images and other special request will apply.

Per Ohio Revised Code 3701.741 , the following are the fees for providing copies of medical records.

- I. Request by patient or patient's personal representative:  
\$2.84/pp for first 10pages, \$0.59/pp for pages 11-50 and \$0.24/pp for greater than 51 pages  
Postage and Handling will be charged as incurred by provider.
- II. Request is made other than by a patient or patient's personal representative:  
\$17.48 for records search  
\$1.15/pp for first 10pages, \$0.59/pp for pages 11-50 and \$0.24/pp for greater than 51 pages  
Postage and Handling will be charged as incurred by provider.
- III. Free copy of Medical Records to the following requesting agencies:  
Bureau of Worker's Compensation, Industrial Commission, ODJFS, Attorney General, and if the patient has an active claim under the "Social Security Act."

Refer to Chapter 3707-83 of the Department of Health Administrative Code for updates and requirements.

I have received and reviewed a copy of the fees that may apply to my above request. I accept responsibility for the payment of these fees personally.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(Parents/guardian if patient is a minor)

Patient's Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_ Signature of Witness: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ AGE: \_\_\_\_ RACE: \_\_\_\_\_

**Past Medical History:** Please check all that apply, list the year the condition started and any explanation.

- |  |  |
|--|--|
| <input type="checkbox"/> Diabetes: _____   | <input type="checkbox"/> Heart attack: _____         |
| <input type="checkbox"/> Congestive Heart Failure: _____                           | <input type="checkbox"/> High Blood Pressure: _____  |
| <input type="checkbox"/> High Cholesterol: _____                                   | <input type="checkbox"/> Thyroid Disease: _____      |
| <input type="checkbox"/> Peripheral Vascular Disease: _____                        | <input type="checkbox"/> Cancer (name source): _____ |
| <input type="checkbox"/> Stroke: _____   | <input type="checkbox"/> Irregular Heart Beat: _____ |
| <input type="checkbox"/> Lung Disease: _____                                       | <input type="checkbox"/> Liver Disease: _____        |
| <input type="checkbox"/> Kidney Disease: _____                                     | <input type="checkbox"/> Anemia: _____               |
| <input type="checkbox"/> Osteoporosis/Osteopenia: _____                            | <input type="checkbox"/> GERD/ Reflux: _____         |
| <input type="checkbox"/> Sleep apnea: _____  |  |
| <input type="checkbox"/> Any Other Medical Conditions that not listed above: _____ |  |

**Past Surgical History:** (Please list all surgeries and procedures.)

<u>Name of Surgery/Procedure</u>	<u>Hospital</u>	<u>Date</u>
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

• Have you had pace maker/stent placement done in the past? Yes / No  
Where did you have it done? \_\_\_\_\_

**Social History:**

Do you smoke?  Yes  No Packs per Day \_\_\_\_ Years \_\_\_\_

Have you ever smoked?  Yes  No If so, year quit \_\_\_\_ Packs Per Day \_\_\_\_ x Years \_\_\_\_

Do you drink alcohol?  Yes  No If yes, how much?

Have you ever drunk alcohol?  Yes  No If so, year quit \_\_\_\_\_

Do you currently or have you ever used Illicit Drugs? \_\_\_\_\_

Occupation: \_\_\_\_\_

Living arrangements: \_\_\_\_\_

Marital Status:  married  single  widowed  divorced

**Family History:** (Mother or Father)

Cancer \_\_\_\_\_,  Heart Disease \_\_\_\_\_,  High Blood Pressure \_\_\_\_\_

Diabetes \_\_\_\_\_,  Osteoporosis \_\_\_\_\_.



**Review of Systems:**

Please circle YES or NO for each and provide explanation in the space provided.

**Eyes:**

- Eye Disease/Injury: Yes / No
- Glasses/Contact Lenses: Yes / No
- Blurred/Double Vision: Yes / No
- Glaucoma: Yes / No
- Cataracts: Yes / No

**Cardiovascular:**

- Chest Pain/Angina: Yes / No
- Palpitations: Yes / No
- Shortness of Breath with Walking:  
Yes / No  
If Yes – How long can you walk?  
\_\_\_\_\_

- Swelling of Feet/Hands: Yes / No
- Heart Trouble: Yes / No

**Respiratory:**

- Shortness of Breath: Yes / No
- Chronic/Frequent Cough: Yes / No
- Spitting up blood: Yes / No
- Asthma / COPD: Yes / No

**Constitutional Symptoms:**

- Fever Yes / No
- Weight Gain or Loss Yes / No

**Neurological:**

- Lightheadedness/Dizzy: Yes / No
- Convulsions/Seizures: Yes / No
- Paralysis: Yes / No
- Numbness /Tingling: Yes / No
- Frequent Headaches: Yes / No

**Psychiatric:**

- Memory Loss/Confusion: Yes / No
- Nervousness: Yes / No
- Depression: Yes / No
- Insomnia: Yes / No

**Gastrointestinal:**

- Loss of Appetite: Yes / No
- Change in Bowel Movements:  
Yes / No
- Nausea/Vomiting: Yes / No
- Frequent Diarrhea: Yes / No
- Constipation: Yes / No
- Blood in stool / Rectal Bleeding:  
Yes / No
- Abdominal Pain: Yes / No
- Heartburn: Yes / No
- Peptic Ulcer (stomach/duodenal):  
Yes / No

**Musculoskeletal:**

- Joint Pain: Yes / No  
Where: \_\_\_\_\_
- Legs cramp with walking: Yes / No
- Difficulty Walking: Yes / No
- Weakness of Muscles or Joints:  
Yes / No
- Muscle Pain or cramps: Yes / No
- Cold Extremities: Yes / No
- Impotence: Yes / No

**Endocrine:**

- High Cholesterol Yes / No
- Excessive Thirst: Yes / No
- Increased Urination: Yes / No
- Heat or Cold Intolerance: Yes / No

**Hematologic/Lymphatic:**

- Phlebitis: Yes / No
- Past Blood Transfusion: Yes / No
- Bleeding or Bruising Tendency:  
Yes / No
- Slow to Heal After Cuts: Yes / No
- Previous Blood Clot Yes / No