Dayton Interventional Radiology, LLC Patient Registration Form
3075 Governors Place, Dayton, OH 45409

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 Worker's Compensation Claim? ☐ **Yes /** ☐ **No**
We will need a completed and approved C9 form in order to provide services for a worker's compensation claim.

Policy Holder Name **Social Security Number** **Date of Birth**

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 Worker'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 Worker'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 Dr. Mubin Syed. 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**

Dayton Interventional Radiology, LLC

3075 Governors Place Suite 120
Dayton, Ohio 45409
Phone: 937-424-2580
Fax: 937-424-2581

Mubin Syed, M.D. FSIR
Kamal Morar, M.D.
Robert Tyrrell, M.D.
Matthew Sebastian, M.D.

Financial Policy for Dayton Interventional Radiology

Effective 1-1-2019, there will be a $25 charge for any office visit appointment that is not cancelled at least 24 hours before the scheduled time, and a $50 fee for any procedure not cancelled at least 24 hours before the scheduled time. This fee must be paid in full before any other services are rendered. After the third "no show", the practice will discharge the patient from the practice and will no longer provide future services. There is also a fee for any returned check in the amount of $50 and no future checks will be accepted.

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. If a patient does not pay the co pay at the time of service, there will be an additional billing fee of $15.00 that must be paid in full before any other services are rendered.

There will be a $30 fee to complete all paperwork requested to be filled out related to treatment, work restrictions or benefits and is required to be paid in full before completed. The forms will be completed within 14 business days.

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. Balances are encouraged to be paid in full within 90 days, with 50% being paid before services are rendered. 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. No additional services will be performed if there is an unpaid balance or a payment agreement is in default.

For all insured patients, 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 patient's 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 department. 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.

In the event of an overpayment, a refund check will be issued to the patient within 90 days after all insurance processing and appeals are completed. If there are future appointments, the account credit will be applied toward those visits.

_____ _____

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

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 by USPS mail and or by phone with myself, a family member, or voice mail.

☐ Yes ☐ No

If you answered no please list any restrictions_____

2. I authorized Dayton Interventional Radiology and employees to give lab results or any other diagnostic study done (both positive and negative), by USPS mail and or by phone with myself, a family member, or voice mail.

☐ Yes ☐ No

If you answered no please list any restrictions_____

3. I authorized 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 prescriptions the doctor authorized.

☐ Yes ☐ No

Please list your pharmacy name and phone number_____

4. I authorize Dayton Interventional Radiology to discuss my Personal Health Information to the following individuals: (please list first and last name along with relationship to patient)

_____

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

_____
Patient Name (print)

_____
Patient Signature

_____
Date

Dayton Interventional Radiology **Name: _____ Date: ____/____/_____**

MR#: _____ **DOB: ____/____/_____** **AGE: ____**

RACE: _____ **HISPANIC/LATINO? ☐ YES / ☐ NO** **LANGUAGE:_____**

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

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

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

	Name of Surgery/Procedure	Hospital	Date
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

- 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_____.

Dayton Interventional Radiology **Name: _____ Date: ____/____/_____**

MR #: _____ DOB: ___/____/____

Allergies: _____

Please list any known allergies (medication, food, etc. and reactions.)

Medication List

Name	Dose	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please use the back of this form if further room is needed for medications. (Please select)

Do you take: ☐ PLAVIX, ☐ ASPIRIN, ☐ COUMADIN, ☐ VITAMIN E, ☐ CELEBREX, ☐ IBUPROFEN, ☐ MOTRIN OR ☐ ADVIL?

Dayton Interventional Radiology **Name: _____ Date: ____/____/_____**
MR #: _____DOB:____/____/____

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 / 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 / Joints: ☐ Yes / ☐ No
- Muscle Pain / Cramps: ☐ Yes / ☐ No
- Cold Extremities: ☐ Yes / ☐ No
- Impotence: ☐ Yes / ☐ No

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

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

Genitourinary:
- Cloudy Urine: ☐ Yes / ☐ No
- Cramping ☐ Yes / ☐ No
- Dribbling ☐ Yes / ☐ No
- Discharge ☐ Yes / ☐ No
- Urgency / Frequency ☐ Yes / ☐ No
- Hematuria ☐ Yes / ☐ No
- Polyuria ☐ Yes / ☐ No
- Painful Urination / Dysuria: ☐ Yes / ☐ No
- Reduced Stream: ☐ Yes / ☐ No
- Incontinence: ☐ Yes / ☐ No
- Renal Stones: ☐ Yes / ☐ No
- Urinary Retention: ☐ Yes / ☐ No

Allergic / Immunologic:
- Facial Swelling ☐ Yes / ☐ No
- Hives: ☐ Yes / ☐ No
- Itchy Eyes / Congestion: ☐ Yes / ☐ No
- Sneezing ☐ Yes / ☐ No
- Wheezing ☐ Yes / ☐ No

Integumentary (Skin/Breast):
- Blisters: ☐ Yes / ☐ No
- Cellulitis ☐ Yes / ☐ No
- Change in Skin Color: ☐ Yes / ☐ No
- Dermatitis: ☐ Yes / ☐ No
- Dry Skin: ☐ Yes / ☐ No
- Ecchymosis: ☐ Yes / ☐ No
- Jaundice ☐ Yes / ☐ No
- Laceration ☐ Yes / ☐ No
- Psoriasis ☐ Yes / ☐ No
- Skin Ulcer: ☐ Yes / ☐ No
- Warts ☐ Yes / ☐ No