EFTA00282926

EAST RIVER MEDICAL IMAGING, PC

PATIENT INFORMATION RECORD

Date: 10/14/2015 Medical Record Number #: 0315192

Patient Name: EPSTEIN, JEFFREY Social Security #: 090-44-3348

Address: [redacted] Apt/Unit/Suite:

City: SAINT THOMAS State: VI Zip: 00802 E-Mail:

Date of Birth: 01/20/1953 Primary Phone #: [redacted]

Please validate your referring physician and contact information by marking the check boxes below.

- ☐ Referring Physician: MOSKOWITZ, BRUCE W, M.D, M.D.
- ☐ Referring Physician's Address: 1411 NORTH FLAGLER DRIVE SUITE 7100 WEST PALM BEACH, FL 33401
- ☐ Referring Physician's Phone: [redacted]

Your referring Physician that has ordered this procedure will receive reports, films and/or CD (their preference). Please indicate by marking in the check box if you would like any additional processing to yourself or other physicians

Additional Physicians Name: _____ Address: _____

Additional Reports To: _____ Address: _____

☐ Report Only **(No Charge)** ☐ Report & CD **($25.00)** ☐ Report & Films **($200.00)**

Insurance Information

Insurance Company: Group #:

Insured's Name: Insured's DOB:

Insured's ID#: Relation to patient:

Do you have supplemental/secondary insurance? ☐ Yes ☐ No

If yes, Insurance Company: Insured's ID #:

Has your insurance changed since your last visit? ☐ Yes ☐ No

(**if yes**, please fill out insurance information above and supply your new insurance card(s) to the front desk receptionist.)

EXAMS TODAY

Date / Time	Exam Code	Referring Name	Accession
10/14/2015 7:30 AM EDT	MRLSPNI	MOSKOWITZ, BRUCE W, M.D	6784742

PAYMENT IS DUE AT THE TIME OF SERVICE

☐ Cash ☐ Check ☐ Mastercard ☐ Visa ☐ Amex ☐ Discover

I HEREBY ACKNOWLEDGE THAT I AM FULLY RESPONSIBLE FOR ANY UNPAID BALANCES.

Signature of Patient or Guardian: _____

EAST RIVER
MEDICAL IMAGING, PC

OUTSIDE FILMS/CD FORM

Date: 10/13/15

Patient Name: EPSTEIN, JEFFREY

Medical Record Number #: 0315192

Do you have any relevant outside studies (films/CD) with you?

☐ Yes ☐ No

If Yes, please check the box as to how you would like your outside images returned

☐ Upload CD to our system and take back with you

☐ Return CD/Film to my home address on file

☐ Return CD/Film to my referring physician

Patient Signature _____

Front Desk Receptionist Name _____

Front Desk Receptionist Signature _____

EAST RIVER
MEDICAL IMAGING, PC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, EPSTEIN, JEFFREY , have received the Notice of Privacy Practices from East River Medical Imaging, PC.

PATIENT SIGNATURE: _____ 10/13/15

In lieu of patient signature, I, _____, a staff member of East River Medical Imaging, PC state that the patient named above has been given our current Notice of Privacy Practices.

STAFF SIGNATURE: _____ DATE: _____

PATIENT NAME: EPSTEIN, JEFFREY
0315192

EFTA00282929

EAST RIVER MEDICAL IMAGING, PC

PATIENT HEALTH HISTORY - MEANINGFUL USE

Patient Name: EPSTEIN, JEFFREY MRN #: 0315192 Exam Date: 10/14/2015

Age: 62 Years DOB: 01/20/1953 Sex: ■ Male ☐ Female

Height: _____ **Feet** _____ **Inches** **Weight:** _____ **lbs**

Is English your Preferred Language? ☐ Yes ☐ No

If not, please specify your preferred language: _____

What is your ethnicity?

☐ Hispanic or Latino ☐ Not Hispanic or Latino
☐ Unknown ☐ I choose not to specify

What is your race?

☐ African American ☐ Caucasian ☐ Asian ☐ Hawaiian/ Pacific Islander
☐ American Indian/ Alaskan ☐ Other ☐ Unknown ☐ I choose not to specify

What is your current tobacco smoking status?

☐ Never a smoker ☐ Current every day smoker ☐ Current some day smoker
☐ Former smoker ☐ Current status unknown ☐ Unknown if ever smoked

Are you taking any medications? ☐ Yes ☐ No

If so, please list: (Name / Dose)	Dosage		Dosage
Name: _____	_____	Name: _____	_____
Name: _____	_____	Name: _____	_____
Name: _____	_____	Name: _____	_____

Are you allergic to any of the following medications/drugs?

☐ **No Known Drug Allergies** ☐ Penicillin ☐ Benadryl
☐ CT Contrast (iodinated Contrast) ☐ Versed ☐ Fentanyl
☐ MRI Contrast (Gadolinium) ☐ Xanax ☐ Epinephrine
☐ Barium ☐ Sulfa ☐ Other

If Other Drug allergies, Please List: _____

Why did you opt for paper forms?

☐ I prefer paper forms ☐ I don't like technology
☐ I was not offered the iPad ☐ Other: _____

EFTA00282930

EAST RIVER MEDICAL IMAGING, PC

MAGNETIC RESONANCE IMAGING (MRI)

Patient Name: EPSTEIN, JEFFREY MRN #: 0315192 Exam Code: MRLSPNI

Age: 62 Years Sex: M Height: Feet Inches Weight: lbs Exam Date: 10/14/2015

Referring Physician: MOSKOWITZ, BRUCE W, M.D. M.D. Acc# 6784742

IMPORTANT: Please notify the receptionist if you answer **"YES"** to any of the questions below. The receptionist will inform the technologist/radiologist of your response.

YES	NO	PLEASE CHECK:
☐	☐	Have you had metal removed from your eyes?
☐	☐	Have you been shot with bullets, BB's or shrapnel?
☐	☐	Are you pregnant?
☐	☐	Are you nursing?
☐	☐	Are you on hemodialysis or peritoneal dialysis?
☐	☐	Do you require oxygen or an inhaler?
☐	☐	Do you have renal disease? If yes please describe _____
☐	☐	Are you wearing any metallic items?
☐	☐	Any surgery on the area to be imaged? If yes, when? _____
☐	☐	Any surgery on your eyes, ears brain or heart?

YES	NO	DO YOU HAVE ANY OF THE FOLLOWING IN YOUR BODY?
☐	☐	Brain/Aneurysm Clips
☐	☐	**Pacemaker, Pacer Wires or Defibrillator** if yes, make\ year _____
☐	☐	Ear Implants or Hearing Aids
☐	☐	Electrical Stimulators
☐	☐	Implant/Prosthesis
☐	☐	Infusion Pumps
☐	☐	Coils, Catheters, Filters or Wires in blood
☐	☐	Artifical Limbs or Joint Replacement
☐	☐	Tattooed Eyeliner
☐	☐	Artificial Heart Valves
☐	☐	Stents If yes, please provide date of implant: _____
☐	☐	Magnetic Dental Implants
☐	☐	Transdermal Patches
☐	☐	IUD
☐	☐	Tissue expander for future implants
☐	☐	Bone Stimulators, Insulin Pumps, or Mechanical Valves
☐	☐	Programmable Shunts

WARNING: **Before entering the MR room, you must remove all metallic objects including HEARING AIDS, DENTURES, CREDIT/BANK CARDS, watch, keys, cell phone, beeper, hair pins, barrettes, body piercing jewelry, money clips, magnetic strip cards, pens, pocket knife, and nail clipper. Please consult the technologist if you have any questions or concerns BEFORE you enter the MR room.**

Signature: _____ Print Name: _____ Date: 10/14/2015

Technologist's Use Only

Patient Complaint/Diagnosis: _____

_____

Any previous imaging studies in this area? ☐ YES ☐ NO

If yes, where? _____

Technologist: _____ Wet Reading ☐ YES ☐ NO Dr's Phone Number: _____

EAST RIVER MEDICAL IMAGING, PC

SIGNATURE ON FILE/INSURANCE AUTHORIZATION CARD

* I AUTHORIZE USE OF THIS FORM FOR ALL MY INSURANCE SUBMISSIONS;
* I AUTHORIZE THE RELEASE OF INFORMATION TO ALL MY INSURANCE COMPANY(S);
* I UNDERSTAND I AM RESPONSIBLE FOR MY BILL.
* I AUTHORIZE MY DOCTOR TO ACT AS MY AGENT IN HELPING ME OBTAIN PAYMENT FROM MY INSURANCE COMPANY(S);
* I AUTHORIZE PAYMENT DIRECTLY TO MY DOCTOR; AND
* I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL.

PATIENT NAME: EPSTEIN, JEFFREY

ID NUMBER:

DATE: 10/14/2015

PATIENT SIGNATURE: _____

FOR OFFICE USE ONLY:

MRN#: 0315192

Signature on File Form 02-2007

EFTA00282932

EAST RIVER MEDICAL IMAGING, PC

MAGNETIC RESONANCE IMAGING (MRI)

Patient Name: EPSTEIN, JEFFREY MRN #: 0315192 Exam Code: MRLSPNI

Age: 62 Years Sex: M Height: Feet Inches Weight: lbs Exam Date: 10/14/2015

Referring Physician: MOSKOWITZ, BRUCE W, M.D. M.D. Acc# 6784742

IMPORTANT: Please notify the receptionist if you answer **"YES"** to any of the questions below.
The receptionist will inform the technologist/radiologist of your response.

YES	NO	PLEASE CHECK:
☐	☐	Have you had metal removed from your eyes?
☐	☐	Have you been shot with bullets, BB's or shrapnel?
☐	☐	Are you pregnant?
☐	☐	Are you nursing?
☐	☐	Are you on hemodialysis or peritoneal dialysis?
☐	☐	Do you require oxygen or an inhaler?
☐	☐	Do you have renal disease? If yes please describe _____
☐	☐	Are you wearing any metallic items?
☐	☐	Any surgery on the area to be imaged? If yes, when? _____
☐	☐	Any surgery on your eyes, ears brain or heart?

YES	NO	DO YOU HAVE ANY OF THE FOLLOWING IN YOUR BODY?
☐	☐	Brain/Aneurysm Clips
☐	☐	**Pacemaker, Pacer Wires or Defibrillator** if yes, make\ year _____
☐	☐	Ear Implants or Hearing Aids
☐	☐	Electrical Stimulators
☐	☐	Implant/Prosthesis
☐	☐	Infusion Pumps
☐	☐	Coils, Catheters, Filters or Wires in blood
☐	☐	Artifical Limbs or Joint Replacement
☐	☐	Tattooed Eyeliner
☐	☐	Artificial Heart Valves
☐	☐	Stents If yes, please provide date of implant: _____
☐	☐	Magnetic Dental Implants
☐	☐	Transdermal Patches
☐	☐	IUD
☐	☐	Tissue expander for future implants
☐	☐	Bone Stimulators, Insulin Pumps, or Mechanical Valves
☐	☐	Programmable Shunts

WARNING: **Before entering the MR room, you must remove all metallic objects including HEARING AIDS, DENTURES, CREDIT/BANK CARDS, watch, keys, cell phone, beeper, hair pins, barrettes, body piercing jewelry, money clips, magnetic strip cards, pens, pocket knife, and nail clipper. Please consult the technologist if you have any questions or concerns BEFORE you enter the MR room.**

Signature: _____ Print Name: _____ Date: 10/14/2015

Technologist's Use Only

Patient Complaint/Diagnosis: _____

_____

Any previous imaging studies in this area? ☐ YES ☐ NO

If yes, where? _____

Technologist: _____ Wet Reading ☐ YES ☐ NO Dr's Phone Number: _____

EAST RIVER MEDICAL IMAGING, PC

Patient Experience Questionnaire

Welcome to the East River Medical Imaging Patient Experience Questionnaire. This is an opportunity to openly share your thoughts about your recent experience. We will not ask any private questions - only about your experience at our medical offices. Your responses will help us strengthen our services to the high level of expectation that you deserve as our patient.

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1. **Was this your first visit to one of our four East River Medical Imaging offices?**
   - ☐ Yes ☐ No ☐ Maybe (I have had radiology tests in the past, but I do not remember where)

2. **How did you hear about East River Medical Imaging?**
   - ☐ Referring Physician ☐ Existing Patient/Return Visit ☐ General Internet Search (Google)
   - ☐ Family or Friend ☐ Advertisement ☐ Other: _____

3. **Which East River Medical Imaging office did you have your test(s)?**
   - ☐ 519 East 72nd Street ☐ 523 East 72nd Street (B Level) ☐ 523 East 72nd Street (C Level)
   - ☐ 3 East 75th Street ☐ 430 East 59th Street ☐ I do not remember

4. **What test(s) did you have done at your most recent visit to East River Medical Imaging?**
   - ☐ MRI ☐ CT ☐ PET/CT ☐ CT Myelogram
   - ☐ X-Ray / Fluoroscopy ☐ Coronary CT Angiogram ☐ Biopsy
   - ☐ General Ultrasound ☐ Breast Ultrasound ☐ Mammogram
   - ☐ Breast MRI ☐ Nuclear Scan ☐ Port Placement
   - ☐ PICC Line Insertion ☐ Thoracentesis ☐ Paracentesis
   - ☐ Dental Imaging ☐ Bone Density Scan
   - ☐ I do not remember ☐ Other: _____

5. **Did you or family member/friend schedule your appointment or did your referring physician's offi**
   - ☐ I made the appointment ☐ A friend/family made appointment ☐ My physician/office

6. **If <u>YOU DID NOT MAKE APPOINTMENT</u>, please skip this question.**
   If you made the appointment, on a scale of 0 to 10 (with 0 being extremely low and 10 being extremely high), how would you rate the scheduling person at East River?

Friendliness	0	1	2	3	4	5	6	7	8	9	10
Professionalism	0	1	2	3	4	5	6	7	8	9	10

7. **Were you immediately greeted by our front office staff in a friendly manner when you arrived?**
   ☐ Yes ☐ No ☐ I do not remember

8. **Did your test(s) begin…**
   ☐ On or Ahead of Time ☐ Less than 15 minutes late ☐ 15-30 minutes late ☐ 30+ minutes late

9. **If your test began late, did our scheduling coordinator, front office staff or technologist provide a reasonable explanation?**
   ☐ Yes ☐ No ☐ I do not remember

10. **Did the technologist or radiologist explain the details of the test in a clear manner?**
    ☐ Yes ☐ No ☐ I do not remember

11. **Were you made to feel comfortable throughout the test by the technologist or radiologist?**
    ☐ Yes ☐ No

12. **Based on your OVERALL experience at East River Medical Imaging, how likely is it that you wou recommend our office to a friend, family member or colleague? Please provide your honest answer a scale between "0" and "10" with "10" being "extremely likely to recommend" and "0" being "n very likely to recommend."**

    0 1 2 3 4 5 6 7 8 9 10

13. **Is there anything that we can do to ensure you receive the highest standard of medical care at our offices? What could have made your test experience better? We appreciate your honesty.**

    _____

    _____

    _____

14. **If you would like a member of our management team to contact you regarding your experience,**

please provide your name: _____

Preferred Phone or E-mail: _____