Front Range Preventive Imaging

Patient Information Form

Cruxpoint Referred Patient

Today's Date: _____

Last Name: _____ First: _____ MI: _____ Marital Status: _____

Sex: ☐ Male ☐ Female Birth Date: ____/____/_____ Age: _____ Height: ____'____" Weight: _____lbs

Race: ☐ African American ☐ Asian ☐ Caucasian ☐ Other _____ ☐ Decline to report

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Other _____ ☐ Decline to report

Primary Language Spoken: ☐ English ☐ Spanish ☐ Russian ☐ Other_____ ☐ Decline to report

Mailing Address: _____ Apt / Unit:_____

City: _____ State: _____ ZIP: _____ Phone: (_____)_____

Employer: _____ Work: (_____)_____

Emergency Contact: _____ Phone: (_____)_____

To provide you with up to date information about our practice we would appreciate your email address.
We keep our email list strictly confidential.

Email (Please print legibly): _____

Have you previously had a Heart Scan at this office: ☐ **Yes** ☐ **No**

Patient referred by Cruxpoint: ☐ **Yes** ☐ **No**

If yes, a copy of the heart scan results will be sent to Cruxpoint. I further give permission to Front Range Preventive Imaging to release to Cruxpoint all of the patient forms, authorizations, consents and intake information related to this heart scan.

I understand that Cruxpoint is responsible for the payment of my first heart scan and I will not be charged. Cruxpoint is responsible for the follow-up and review of the scan results.

Would you like a copy to go to a medical provider(s)? ☐ YES ☐ NO
If YES please provide the following:

_____
Physician's First and Last Name

_____
Physician's Address

_____ ( )
Physician's City State Zip Phone

_____ / /
Patient Signature Date

The EBT machine has a weight restriction of less than 300 pounds.

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Heart Scan Health History

Cruxpoint Referred Patient

Name: _____ Date of Birth: _____

MEDICAL HISTORY

Do you have a personal history of cancer? ☐ YES ☐ NO
What kind? _____

Have you had a previous heart scan? ☐ YES ☐ NO Where?_____

Have you had a previous CT scan of your chest? ☐ YES ☐ NO Where?_____
Results: ☐ Normal ☐ Unavailable
☐ Abnormal: suspicious for cancer ☐ Abnormal: not suspicious for cancer

Have you had a previous X-ray of your chest? ☐ YES ☐ NO Where? _____
Results: ☐ Normal ☐ Unavailable
☐ Abnormal: suspicious for cancer ☐ Abnormal: not suspicious for cancer

Cholesterol ☐ High ☐ Normal ☐ Low ☐ Unknown
List your cholesterol medications: _____

Smoking History ☐Former ☐ Never ☐Current
If you ***currently*** smoke: Packs/ day _____ Years smoking _____

If you are an ***ex-smoker***: Average packs/day: _____ Total years smoked: _____
Approximate number of years since quitting: _____

Blood Pressure ☐ High ☐ Normal ☐ Low ☐ Controlled with medication
If high, number of years: _____
List your blood pressure medications:
_____

Please check any conditions you have had:

☐ Diabetes: ☐ Taking Insulin
☐ Other Diabetes Medications: _____

☐ Chest Pain
☐ Chest Tightness
☐ Chest Pressure
☐ Unusual Cough
☐ Fatigue
☐ Dizziness
☐ Shortness of Breath
☐ Heart Burn
☐ Abnormal EKG
☐ Frequent Palpitations
☐ Fainting

☐ Heart Disease If yes, describe: _____

Are you **currently** experiencing any of the above symptoms? If yes, please describe:

_____

_____

FAMILY HISTORY

Please check all that apply

☐ Unknown Family History

	Stroke	High Blood Pressure	Diabetes	Heart Disease before 55	Heart Disease after 55
Parent	☐	☐	☐	☐	☐
Sibling	☐	☐	☐	☐	☐
Grandparent	☐	☐	☐	☐	☐

PAST CORONARY/CARDIAC PROCEDURES ***YOU HAVE HAD***: (Check all that apply)

☐ CABG (Bypass) ☐ Angiography ☐ PTCA (Balloon angioplasty)

☐ Coronary Stent: How many_____ which artery? _____

MISCELLANEOUS INFORMATION

Current level of exercise (check one)

☐ Unable to quantify
☐ None
☐ Less than 30min. 2-3 times/week
☐ 30-45min 2-3 times/week
☐ 45-60min 2-3 times/week
☐ More than 60min 2-3 times/week

Current level of stress (check one)

☐ Unable to quantify
☐ Low
☐ Average
☐ Above average
☐ High
☐ Very high

CURRENT MEDICATIONS: (check all that you are taking)

☐ Daily Aspirin
☐ Antioxidants
(*examples*: Vitamins A, C and E,
Beta-Carotene, or Supplements labeled Antioxidant)
Please list antioxidants you take:
_____
_____

☐ Fish Oil
☐ Niacin
☐ Vitamin D
☐ Aged Garlic Extract
☐ K2
☐ Additional heart health supplements: (please list)
_____
_____

WOMEN ONLY: Are you pregnant? ☐ YES ☐ NO
Do you have any reason to think that you could be pregnant? ☐ YES ☐ NO

_____ / /
Print Name Date of Birth

_____ / /
Patient Signature Date

Front Range Preventive Imaging

EBCT Heart Screening Disclosure and Consent

Cruxpoint Referred Patient

I voluntarily consent and authorize Front Range Preventive Imaging physicians, technologists, and Medical assistants to administer the testing required to perform the EBCT Ultrafast Cardiac screening test.

IF YOU ARE CURRENTLY EXPERIENCING CHEST SYMPTOMS: PAIN, SHORTNESS OF BREATH, ETC, YOU MUST PROVIDE US WITH A PHYSICIAN'S NAME TODAY

I understand that:

1. I will be exposed to radiation during the scan.
2. The primary purpose of the Heart Scan is to identify calcified plaque in the coronary arteries of the heart, the increase in which has been shown to correlate with the risk of coronary disease and coronary events.
3. This test cannot and is not intended to detect every possible heart defect or disease state. Among other things, it does not detect electrical abnormalities, decreased blood flow, congenital defects or morphologic abnormalities.
4. Although this screening can help identify certain coronary disease, it should not be considered a substitute for a thorough examination or other testing recommended by a physician.
5. A normal scan (or a zero score) does not guarantee that I will not have a heart attack or need treatment for coronary disease.
6. As a part of the EBCT Heart Scan, a portion of my lung will be imaged and reviewed by a radiologist to identify any abnormalities in the lung window. This is not a substitute for a complete Lung Scan and is not perfect and may miss some abnormalities including cancers at the very early stages of development and those outside of the field of view.
7. If any abnormalities are found, I understand that other testing and/or diagnostic procedures may be needed to further evaluate the findings and that such tests and/or procedures may entail additional costs for which I am responsible.
8. **I understand that Front Range Preventive Imaging is not responsible for my follow-up medical care. Results will be forwarded to Cruxpoint for review with me.**
9. My results will be made available to a physician of my choice if I so request.

I have been given an opportunity to ask questions about this procedure and the risks and hazards involved and I believe that I have sufficient information to give informed consent. I certify that I have read this form and I understand its contents.

_____ / / _____

Signature Date

Front Range Preventive Imaging

Cruxpoint Referred Patient

Messages and Disclosure Information

In an effort to protect your privacy, we have developed a policy on leaving medical care messages.

We will NOT leave messages with anyone except the patient or legal guardian.
We will NOT leave any information on an answering machine / voice mail.
***UNLESS* we have your written permission to do so.**
Please read below and consider carefully whom you want to have access to your medical information.

I give Front Range Preventive Imaging my permission to communicate with and to leave phone messages regarding my medical care on the provided numbers and/or to the listed persons. I fully understand that this authorization will remain valid until revoked in writing.

My home / mobile answering machine / voice mail: Phone: (_____)_____

My office / work voice mail: Phone: (_____)_____

My spouse: Name _____ Phone: (_____)_____

Cruxpoint Health Breakthrough, Inc. **Phone: (303) 530-1605**

_____ / / _____

Patient Signature Date

Boulder Internal Medicine
&
Front Range Preventive Imaging

2880 Folsom St, Suite 100
Boulder, CO 80304
Privacy Officer: Donna Blanchet
Phone: 303-327-7047
Email:
dblanchet@boulderinternalmed.com

Notice of Health Information Practices

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Introduction

At Front Range Preventive Imaging, we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice applies to all protected health information as defined by federal regulations.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities.

Obtain an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may refuse your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will agree to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or healthcare item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and healthcare operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/**
- We will not retaliate against you for filing a complaint.

Your Choices:

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Most sharing of psychotherapy notes

We do not engage in fundraising nor will we ever sell your information for any purpose.

Our Uses and Disclosures

We typically use or share your health information in the following ways.

Treat you: We can use your health information and share it with other professionals who are treating you.
Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization: We can use and share your health information to run our practice, improve your care, and contact you when necessary.
Example: We use health information about you to manage your treatment and services.

Bill for your services: We can use and share your health information to bill and get payment from health plans or other entities.
Example: We give information about you to your health insurance plan so it will pay for your services.

We are allowed or sometimes required to share your information in other ways – usually in ways that contribute to the public good, such as for public health and research. We have to meet many conditions in the law before we can share your information for these following purposes.
For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

Help with public health and safety issues
We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research: We can use or share your information for health research.

Comply with the law: We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests: We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director: We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Health Information Exchange

We endorse, support, and participate in electronic Health Information Exchange (HIE) as a means to improve the quality of your health and healthcare experience. HIE provides us with a way to securely and efficiently share patients' clinical information electronically with other physicians and healthcare providers that participate in the HIE network. Using HIE helps your healthcare providers to more effectively share information and provide you with better care. The HIE also enables emergency medical personnel and other providers who are treating you to have immediate access to your medical data that may be critical for your care. Making your health information available to your healthcare providers through the HIE can also help reduce your costs by eliminating unnecessary duplication of tests and procedures. However, you may choose to opt-out of participation in the HIE, or cancel an opt-out choice, at any time.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site

I have received and read this Notice of Health Information Practices. I fully understand this Notice and have had all my questions answered.

Print Name

/ /

Patient Signature Date