



LAST NAME _____ **FIRST NAME** _____
ADDRESS _____ **DOB** _____
_____ **SSN** _____
PHONE _____ **CELL** _____ **MALE** _____ **FEMALE** _____

EMPLOYMENT INFORMATION

Company Name _____ Phone Number _____
Address _____ Ext # _____
_____ Position _____

EMERGENCY INFORMATION

Name of Person to Contact in Case of Emergency _____
Phone No _____ Relationship _____

INSURANCE INFORMATION

Primary Insurance Carrier _____
Phone Number _____
Member ID _____ Group ID _____
Insurer's Names _____ Relationship _____

Secondary Insurance Carrier _____
Phone Number _____
Member ID _____ Group ID _____
Insurer's Names _____ Relationship _____

For Auto Accident or Workmen's Compensation Cases

Insurance Company _____ Contact Name _____
Phone Number _____ Claim Number _____
Attorney's Name _____ Contact Name _____
Phone Number _____

RELEASE OF FILMS/ CD

I hereby authorize the following person (s) to pick up copies of my test films (Other than your referring physician):

Name _____ Relationship _____
Name _____ Relationship _____

Have you had any previous exams at this facility Yes _____ No _____

If yes, When? _____ What type of exam _____

PRIMARY PHYSICIAN INFORMATION

Name _____ Phone _____
City/State _____

ASSIGNMENT OF BENEFITS

I, _____, understand that it is my responsibility to provide accurate, current insurance information to **Professional Imaging Centers, Inc.** Furthermore, I understand that as a service to me, **Professional Imaging Centers, Inc.** will file a claim with my insurance carrier. However, all co-payments, deductible amounts, or outstanding account balances must be paid by me at the time of my visits or within 30 days of billed date. I also agree that all charges connected with services rendered to me, not covered by any insurance or other third party coverage, are due and payable within 30 days of my visit, unless arrangements are made otherwise. **I understand that any co-payment amounts collected at the time of visit are only an estimated amount and that other co-payments and charges may be applicable and must be paid by me within 30 days of billed date.**

Patient's Initials _____

Furthermore, I agree, that if I am more than 30 days delinquent in the payment of any bill connected with this service, interest on the amount due may accrue at the maximum rate allowed by law. If the delinquent amount is referred for collection, I agree to pay the attorney's fees, court costs and/or fees associated with the collection process.

ASSIGNMENT OF BENEFITS

I hereby assign to **Professional Imaging Centers, Inc.** reimbursement benefits of all insurance policies otherwise payable to the patient for services rendered. I authorize **Professional Imaging Centers Inc.** to submit claims to insurance companies or plan administrators and to apply insurance proceeds to **Professional Imaging Centers, Inc.** and to make refunds to insurance companies, if refunds are due under the provision of such insurance policies. I also assign all rights, as the insured, to bring an action against my insurance company for benefits due under the insurance policies.

RELEASE OF MEDICAL INFORMATION

I hereby authorize **Professional Imaging Centers** to release information and/or copies of my medical records to any guarantor of payment on my account, any insurance company (including Worker's Compensation carriers and my employer) for which benefits have been assigned.

ATTESTATION

I certify that I have read and accept the foregoing, have received a copy thereof (upon my request), and am personally empowered, or am duly authorized by the patient, as patient's general agent, to execute the above. It is my responsibility to consult with my insurance co. regarding payment and authorizations required prior to my visit.

Patient (or parent/guardian of minor)

Guarantor (if other than patient, parent or legal guardian)

Relationship to patient

____/____/____
Date

The above document was translated by : _____ on _____

DISCLOSURE AUTHORIZATION FOR INFORMATION REQUEST

Pursuant to the Health Insurance Portability and Accountability Act (HIPAA), I, _____, hereby authorize the following providers: (List all providers from whom information is being sought) to disclose the following protected health information to **Professional Imaging Centers**.

(Check as applicable)

- Copies of any diagnostic imaging test taken within the past seven years.
 - Medical history, including specific progress notes regarding any problems that would impact my surgery or procedure's progress or outcome.
 - A list of allergies.
 - Results of relevant diagnostic or laboratory tests.
 - Other:
-

This protected health information is being used by the facility for the purpose of preparation for an outpatient procedure at **Professional Imaging Centers**.

This authorization shall be in force and effect until: ____/____/____

I understand that, as set forth in the health care facility's Privacy Notice, I have the right to revoke this authorization, in writing at any time by sending written notification to:

Professional Imaging Centers
1049 Willa Springs Drive, Suite 1051
Winter Springs, FL 32708
Attn: Privacy Officer

I understand that a revocation is not effective to the extent that the health care facility has relied on the use or disclosure of the protected health information.

I understand that information used and disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that the health care facility will not condition my treatment on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to:

- * Inspect or copy my protected health information to be used or disclosed as permitted under federal law (state law to the extent the state law provides greater access rights).
- * Refuse to sign this authorization.

Signature of Patient or Personal Representative

_____/_____/_____
Date

Print Patient's Name or Personal Representative

DOB: ____/____/____

Description of Personal Representative's Authority