

Account #: _____ Date: _____

Patient's Name: _____ Date of Birth: _____ Social Security: _____

Guarantor Name: _____

Address: _____ City _____ State _____ ZipCode _____

Phone: _____ Cell: _____ Work / Other: _____

Referring Physician: _____ Phone Number _____ Fax _____

Address: _____ City _____ State _____ ZipCode _____

Primary Insurance: _____ Policy No: _____ INS ACTIVE: _____

Secondary Insurance Name and Policy #: _____ INS ACTIVE: _____

Attorney Contact Name and Phone Number: _____

We do require you to pay your co-payments and deductibles at the time of service. We accept cash, checks, Visa, Master Card, and American Express. Please understand that any monies collected at the time of visit are only an estimated amount of your financial responsibility and do not represent the total financial responsibility due for the services rendered. In most cases, we will bill your insurance for you. **Please understand that this is a courtesy to our patients, not our responsibility.** Your insurance contract is between you and your insurance company. It is **YOUR** responsibility to understand the terms and benefits, which are a part of your contract. If you are unsure what your benefits are, you should contact your benefits department for verification prior to your visit.

I have read the foregoing, have received a copy thereof (upon my request), and I 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 company regarding payment and authorizations required prior to my visit. I hereby assign to Professional Imaging Centers, Inc reimbursement benefits of all insurance policies and/or settlements otherwise payable to the patient for service rendered. I authorize Professional Imaging Centers, Inc to submit claims to insurance companies plan administrators, and/or attorneys and to apply insurance proceeds to Professional Imaging Centers, Inc. 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. If your insurance company has not paid your bill in full within 60 days, you will be expected to pay in full the balance. Any balance due from you after your insurance has paid will be due within 30 days from receipt of your statement. In the event of a large balance due, we can arrange a payment plan suitable for all parties concerned.

Patient's Signature

Guarantor (if other than patient) Parent or Legal Guardian Relationship to Patient

FOR OFFICE USE ONLY

Today's Financial Responsibility \$ _____ Previous Balance \$ _____ Total Balance Due \$ _____

Payment by _____ Payment Amount \$ _____ Balance Due \$ _____

Cash, VS, MC, AMEX, Disc, Check/Check No.

BILLING COMMENTS: _____

CC REPORT TO: _____

PREVIOUS THYROID EXAMS _____ PREVIOUS BREAST U/S OR MAMMO _____

PREVIOUS PIC EXAMS _____

VERIFY CURRENT ADDRESS _____ INSURANCE VERIFIED _____ FRONT DESK INITIALS _____

Exam(s) Performed: **TECH** _____ **RAD** _____

CPT CODE	INTERNAL STUDY CODE	CPT CODE	INTERNAL STUDY CODE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

CT / MR CONTRAST CPT CODE _____ UNIT #: _____ ML

PROFESSIONAL IMAGING CENTERS, INC.
1049 WILLA SPRINGS DR., STE 1051
WINTER SPRINGS, FL 32708
Phone: (407) 657-7979
DISCLOSURE AUTHORIZATION FOR INFORMATION REQUEST

Patient's Name _____ **Date of Birth:** _____

Pursuant to the Health Insurance Portability and Accountability Act (HIPPA), 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 and/or Professional Imaging Consultants.

(Check as applicable)

- Copies of any diagnostic imaging tests 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 and/or Professional Imaging Consultants.**

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 -Attn: Privacy Officer
1049 Willa Spring Dr., STE 1051; Winter Springs, FL 32708

I authorize Professional Imaging Centers to release films and/or reports regarding my radiographic exams to treating healthcare providers that will be providing medical treatment or service to me.

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 disclosure.

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 for which benefits have been assigned. I authorize Professional Imaging Centers to release copies of my film(s) to the following person(s) other than my referring physician:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I understand that I have the right to:

- *Revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization
- *The Information released in response to this authorization may be re-disclosed to other parties
- *My treatment or payment for my treatment cannot be conditioned on the signing of this authorization

Signature of Patient or Personal Representative

_____/_____/_____
Date

Print Patient's Name or Personal Representative

Description of Personal Representative's Authority

Fax Reports To: Professional Imaging Centers _____ **Attn:** _____

Patient Will Pick- Up on _____

Courier Will Pick- Up on _____ **Courier Name** _____

Account #: _____

PATIENT INFORMATION

Date: _____

PATIENT'S NAME: _____

DOB: _____

FEMALE PATIENTS:

PREGNANT? YES NO (circle one)
LAST MENSTRUAL PERIOD _____

With the full understanding of the above, I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this time and I wish to have a radiographic examination performed now. There is a risk in the use of radiation and the possibility that it will harm a fetus; thus, if there is a chance that you are pregnant, you should not participate in the study before having a test to confirm non-pregnancy. () Please initial.

CIRCLE IF YOU HAVE OR HAVE EVER HAD:

**ALLERGIC REACTION TO CONTRAST
ALLERGIC TO IODINE/SHELLFISH
ASTHMA
SICKLE CELL DISEASE
RENAL (KIDNEY) DISEASE
DIABETES
HEART DISEASE**

**TAKE GLUCOPHAGE, GLUCOVANCE, OR METFORMING
CARDIAC PACEMAKER
HEART SURGERY
BRAIN ANEURYSM CLIP
ELECTRICAL STIMULATOR
METAL IN EYES
CANCER**

**METAL IMPLANTS IN YOUR BODY
REMOVABLE DENTAL WORK
HEAD SURGERY(BRAIN,EYES,EARS)
METAL SHRAPNEL/FRAGMENTS
TATTOO/PERMANENT MAKE UP**

HYPERTENSION/ HIGH BLOOD PRESSURE

WEIGHT: _____

SEX: _____

WHAT KIND OF SURGERIES HAVE YOU HAD? (TYPE & DATE) _____

LIST ANY ALLERGIES: _____

LIST PRIOR EXAMS RELATED TO TODAY'S STUDY (FACILITY NAME,DATE,EXAM TYPE): _____

HAVE YOU BEEN TO OUR FACILITY BEFORE? _____ WHEN?: _____

Emergency Contact: _____ **Relation:** _____ **Phone Number:** _____

****You may be receiving an intravenous contrast media and/or oral contrast media to enhance the visibility of certain tissues. Possible side effects include, but are not limited to: nausea,a warm flushed feeling, potential allergic reaction including, but not limited to hives, wheezing, difficulty breathing in rare cases, anaphylactic shocks _____ (INITIAL)**

****I,the undersigned, verify that all the answers I have provided are true to the best of my knowledge. I give Professional Imaging Centers the permission to perform the examination(s) requested by my physician. I have read the above and fully understand its contents and all my questions have been answered.**

PATIENT'S SIGNATURE

DATE

PARENT/LEGAL GUARDIAN

RELATION

DO NOT WRITE BELOW THIS LINE

EXAM: MRI MRA CT CTA XRAY: _____ **CONTRAST** _____

DX: _____ **DOI:** _____

SYMPTOMS: _____

RADIOLOGIST: _____ **TECH:** _____ **PRIORS:** _____

COMMENTS: _____

THE ABOVE DOCUMENT WAS TRANSLATED BY _____ ON _____