PROFESSIONAL IMAGING CENTERS, INC.

PROFESSIONAL SERVICE LIEN

Date: _____

Attorney Info:

_____

_____

_____

RE: MEDICAL REPORTS AND PROFESSIONAL SERVICE LIEN

Patient's Name / Date of Birth / Acct #: _____

Address: _____

I do hereby authorize Professional Imaging Centers to furnish you (upon request), my attorney, with a full report of the examination, diagnosis, treatment, prognosis, etc. of myself in regards to the accident on _____ .

I hereby authorize and direct you, my attorney, to pay directly to Professional Imaging Centers such sums as may be due and owing them for medical services rendered to me both by reason of accident and by reason of any other bills that are due to them and to withhold such sums from any settlement, judgment or verdict which may be necessary to adequately protect their bill. I hereby give lien on my case to Professional Imaging Centers against any and all proceeds of any settlement, judgment or verdict which may be paid to my attorney or myself as the result of the injuries for which I have been treated or injuries connected therewith.

I also fully understand that I am directly and fully responsible for all medical bills submitted by them for services rendered to me and that this agreement is made solely for Professional Imaging Centers additional protection and in consideration of them awaiting payment. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

I also fully understand that in the event that I should decide to secure a different attorney, other than the one stated above, he/she (the new attorney) will also honor this disbursement. Any photocopy will be valid as the original and any legal expenses which occur as a result of this lien will be paid to the prevailing party.

I hereby authorize Professional Imaging Consultants/Centers to release any documentation, films or CD, or account details to my attorney.

Date: _____/_____/_____ Patient Signature: _____

Legal Guardian: _____
(if patient is minor)

The undersigned, being attorney of record for the above-named patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to protect Professional Imaging Centers.

Date: _____/_____/_____ Attorney Signature: _____

Attention Attorney: PLEASE READ, SIGN, DATE AND RETURN ONE COPY TO:

Professional Imaging Centers
1049 Willa Springs Dr., Ste 1051, Winter Springs, Fl 32708
Phone (07) 657-7979 Fax (407) 388-0927

PROFESSIONAL IMAGING CENTERS, INC.

STANDARD DISCLOSURE AND ACKNOWLEDGEMENT FORM
PERSONAL INJURY PROTECTION-INITIAL TREATMENT OR SERVICE PROVIDED

The undersigned, _____ , insured person (or guardian of such person) affirms:

1. The services or treatment set forth below were actually rendered. This means that those services have already been provided.

_____

2. I have the right and the duty to confirm that the services have already been provided.
3. I was not solicited by any person to seek any services from the medical provider of the services described above.
4. The medical provider has explained the services to me for which payment is being claimed.
5. If I notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in the amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the amount of the reduction, up to $500.

Insured person (patient receiving treatment or services) or Guardian of Insured Person:

_____	_____	_____
Name (Printed or Type)	Signature	Date

The undersigned licensed medical professional or medical director, if applicable, affirms the statement numbered 1 above and also:

A. I have not solicited or caused the insured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.

B. The treatment or services rendered were explained to the insured person, or his or her guardian, sufficiently for that person to sign this form with informed consent.

C. The accompanying statement or bill is properly completed in all material provisions and all relevant information has been provided therein. This means that each request for information has been responded to truthfully, accurately, and in a substantially complete manner.

D. The coding of procedures on the accompanying statement or bill is proper. This means that no service has been upcoded, unbundled, or constitutes an invalid or not medically necessary diagnostic test as defined by Section 627.732(14) and (15), Florida Statues or Section 627.736(5)(b)6, Florida Statues.

Licensed Medical Professional Rendering Treatment/Services or Medical Director, if applicable(signature by his/her own hand):

_____	_____	_____
Name (Printed or Type)	Signature	Date

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of Claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree per Section 817.234(1)(b), Florida Statues.

Note: The original of this form must be furnished to the insurer pursuant to Section 627.736(4)(b), Florida Statues and may not be
electronically furnished. Failure to furnish this form may result in non-payment of the claim.

OIR-B1-1571
PUB. 1/2004

PROFESSIONAL IMAGING CENTERS, INC.

ASSIGNMENT OF BENEFITS, AUTHORIZATION TO SETTLE CLAIM, AND DIRECTION TO PAY MEDICAL PROVIDER DIRECTLY

PATIENT: _____ DATE: _____

INSURED'S NAME: _____

CLAIM #: _____ ACCOUNT#: _____

By my signature below, for good and valuable consideration (including but not limited to the extension of credit to me for services to be rendered), I hereby assign, transfer, and convey to PROFESSIONAL IMAGING CENTERS, INC. (hereinafter "the Provider") any and all rights, entitlement to, and interest in medical expense reimbursement, medical benefits, or insurance benefits in any form, including but not limited to any automobile liability medical expense benefits or other health benefits indemnification and/or agreement otherwise payable to me. Payment of these benefits shall not exceed my indebtedness to the Provider and I hereby acknowledge I will timely pay any indebtedness owed by me to the Provider that is not otherwise satisfied by the above-referenced assigned insurance proceeds. I also acknowledge any medical expenses not covered under my insurance policy will be my responsibility.

I further authorize the Provider to negotiate, collect, and settle any claim with any insurer or other third party payor. This authorization expressly includes, but is not limited to, the authority to:

(1) Request and receive from any insurer or any other party any and all documentation and records that I, the insured, am entitled to with regard to this claim, including, but not limited to, a statement of coverage, policy declarations page, and insurance policy pursuant to Section 627.4137. In addition, the Provider has the authority to request and receive any of the following: Independent Medical Examination Requests, Independent Medical Examination Reports, Notices regarding appointments for Independent Medical Examinations, Examination Under Oath Requests, Examination Under Oath transcripts or recordings, Records Review or Peer Review Reports, Coverage Denial letters or notices, Explanations of Benefits or Explanations of Review, and any log created and maintained by my insurer of personal injury protection benefits paid by the insurer on my behalf related to this claim.

(2) To endorse, deposit, and collect any check or draft issued for payment of benefits assigned. By way of this assignment and notice, I further instruct the insurer to furnish the Provider with copies of all future notices, investigation, or coverage decision that may affect the insured's or the Provider's interest in this claim.

The Provider hereby objects to any reductions or partial payment of benefits. Any partial or reduced payment, regardless of the accompanying language, issued by the insurer and deposited by the provider shall be done so under protest and at the risk of the insurer. The deposit of any payment shall not be deemed a waiver, accord, satisfaction, discharge, settlement, or agreement by the provider to accept a reduced amount as payment in full.

I further direct my insurer to direct all payments for services rendered by the Provider directly to the Provider at the billing address contained in the Provider's medical bills or otherwise supplied to the insurer.

THIS IS A DIRECT AND IRREVOCABLE ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER MY POLICY OF INSURANCE.

A photocopy of this form shall be considered as effective and valid as the original.

I have read the foregoing and understand and agree to each of the above provisions:

Patient's Signature

Guarantor (if other than patient) Parent or Legal Guardian

Relationship to Patient

PROFESSIONAL IMAGING CENTERS, INC.

ACCIDENT / INJURY INFORMATION

PATIENT NAME: _____

ACCOUNT NUMBER: _____ DATE: _____

DATE OF INJURY: _____

ATTORNEY NAME:_____ GROUP NAME _____

PHONE NUMBER: _____ FAX NUMBER: _____

CIRCLE THE ONE THAT APPLIES:

AUTO MOTORCYCLE BICYCLE OTHER: _____

CIRCLE THE ONE THAT APPLIES: DRIVER PASSENGER PEDESTRIAN

ARE YOU THE AT FAULT PARTY: ☐ YES ☐ NO

WERE YOU HOSPITALIZED: ☐ NO ☐ YES; NUMBER OF DAY IN THE HOSPITAL: _____

LIST EXAMS DONE AT THE HOSPITAL: _____

DID YOU SEEK MEDICAL ATTENTION WITHIN 14 DAYS OF YOUR ACCIDENT: ☐ YES ☐ NO

WHICH DOCTOR: _____

PROFESSIONAL IMAGING CENTERS

Location: _____ Account #: _____ Date of Service: _____

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

Guarantor Name: _____ Email Address: _____

Address: _____ City/State _____ Zip Code: _____

Phone: _____ Cell: _____ Work / Other: _____

May we contact you at any of the phone numbers listed above to discuss medical and financial issues? _____Yes OR Only at my _____ or _____

Referring Physician: _____ Phone Number _____ Fax _____

Primary Insurance: _____ Policy No: _____

Secondary Insurance Name and Policy #: _____

Auto Accident: Attorney Name & Phone Number: _____

Is the above information accurate and correct? Yes _____ No _____ (write correct address/phone number below)

_____

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 money collected at the time of visit is 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 understand that, in the opinion of my referring physician, the services I have requested to be provided to me today are medically necessary, but may not be covered under my insurance carrier as being reasonable and /or medically necessary for my care are non covered benefits. I understand my insurance carrier has established the medical necessity standards for the services I request and receive. I also understand I am responsible for payment of the services I request and receive if these services are determined to be inconsistent with my insurance carrier medically necessary standards for my care or not a covered benefit. 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 the balance in full. 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. I fully authorize Professional Imaging Centers (Consultants), Inc. to submit member's appeals in my behalf when necessary.

_____ _____

PATIENT'S SIGNATURE Guarantor (if other than patient) Parent or Legal Guardian/ relationship

_____ FOR OFFICE USE ONLY _____

Today's Financial Responsibility $ _____ **Previous Balance $** _____ **Other Amts Due $** _____ **Total Due $** _____

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

Payment by _____ #_____ Payment Amount $ _____ Balance Due $ _____ Taken by _____

CC REPORT TO: _____ INS ACTIVE: _____ 2ND INS ACTIVE: _____

AUTHORIZATION CPT CODE _____ DOS _____ EXP DATE _____ AUTH #_____

AUTHORIZATION CPT CODE _____ DOS _____ EXP DATE _____ AUTH #_____

AUTHORIZATION CPT CODE _____ DOS _____ EXP DATE _____ AUTH #_____

PRIOR STUDIES: _____

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

CPT CODE	INTERNAL STUDY CODE	CPT CODE	INTERNAL STUDY CODE

PROFESSIONAL IMAGING CENTERS, INC.

1049 WILLA SPRINGS DR., STE 1051, WINTER SPRINGS, FL 32708; Phone: (407) 657-7979 FAX (407) 678-9938

HIPPA AND DISCLOSURE AUTHORIZATION FOR INFORMATION REQUEST

Name: _____ Date of Birth: _____

I acknowledge that a copy of the Notice of Privacy Practices that outlines how patient confidential information will be used, disclosed, protected, and how I can get access to this information, is available to me upon 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 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 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., Suite 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 andmay 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.

RELEASE OF PROFESSIONAL IMAGING CENTERS' RECORDS (REQUIRES 48 HOURS NOTICE):

I, _____ , hereby authorize Professional Imaging Centers, Inc. to release medical, financial 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 to, and /or to the person (s) listed below:

Name:_____ Relationship:_____ Phone: _____

Name:_____ Relationship:_____ Phone: _____

Name:_____ Relationship:_____ Phone: _____

_____ _____/_____/_____
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: _____

PROFESSIONAL IMAGING CENTERS, INC.

PATIENT INFORMATION

Account Number: _____ Date of Birth: _____

Patient Name: _____ Sex: _____ Weight: _____

Emergency Contact: _____ Relation: _____ Phone Number: _____

FEMALE PATIENTS: PREGNANT? ☐ Yes ☐ No 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 of radiation and magnet pull and the possiblity 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.

CHECK IF YOU HAVE OR HAVE EVER HAD:

☐ ALLERGIC REACTION TO MRI OR CT CONTRAST
☐ ALLERGIC TO IODINE/SHELLFISH
☐ BRAIN ANEURYSM CLIP
☐ RENAL (KIDNEY) DISEASE
☐ ELECTRICAL STIMULATOR
☐ HIGH BLOOD PRESSURE
☐ METAL STENTS
☐ TAKE GLUCOPHAGE,GLUCOVANCE, OR METFORMIN
☐ METAL SHRAPNEL/FRAGMENTS/IMPLANTS
☐ HEAD SURGERY(BRAIN,EYES,EARS)
☐ SICKLE CELL DISEASE
☐ DIABETES
☐ PACEMAKER
☐ HEART DISEASE OR SURGERY

☐ CANCER HISTORY: PRESENT OR PAST /CANCER TYPE: _____

☐ PERSISTENT COUGH: ☐ WITHIN THE LAST 3MOS ☐ LASTING OVER 3MOS

DO YOU SMOKE?: ☐ PRESENTLY ☐ IN THE PAST ☐ SECOND HAND SMOKE EXPOSURE (Check all that apply)

SURGERY HISTORY? (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?: _____

**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 shock _____ (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.

_____ _____ _____

SIGNATURE OR LEGAL GUARDIAN SIGNATURE DATE GUARDIAN RELATIONSHIP

DO NOT WRITE BELOW THIS LINE

EXAM: MR CT XRAY _____ MVA / DOI: _____

CONTRAST_____ DX:_____

PAIN: ASCENDING DESCENDING ACUTE CHRONIC

INJURY/FRACTURE: OPEN CLOSED STRAIN SPRAIN

LOCALITY: LOWER UPPER INNER OUTER RIGHT LEFT BILAT

INITIAL OR FOLLOW STUDY: _____ PRIORS: _____

RADIOLOGIST:_____ TECH: _____

SYMPTOMS/COMMENTS: _____

_____

_____

THE ABOVE DOCUMENT WAS TRANSLATED BY_____ ON _____