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 _____