CHOICE
Diagnostic Imaging

PATIENT INFORMATION

PLEASE PRINT. THANK YOU!

First: _____ MI: _____ Last: _____

Primary Address: _____ Apt: _____

City: _____ State: _____ Zip: _____

Secondary Address: _____ Apt: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Cell Phone: (_____) _____

Date of Birth: _____ Age: _____ E-mail Address: _____

SS #: _____ ☐ MALE ☐ FEMALE

Employer: _____ Work Phone: (_____) _____

How did you hear about us? _____

_____

We welcome any feedback on your visit today. Please feel free to call us directly at 941-954-1900.

ASSIGNMENT OF BENEFITS / MEDICAL RELEASE

I request that payment of authorized benefits be made for any services furnished to me by Choice Diagnostic Imaging, or its legal subsidiaries, affiliates, successor and assigns. If my current policy prohibits direct payment to the provider, I hereby acknowledge that I am responsible for submitting payments received to the provider for services furnished to me by the provider. I also understand that I am financially responsible for services not covered by benefits. I authorize any holder of medical or other information about me to release information needed to any person, accrediting or certifying/professional organizations company and/or agency which is or may be liable for any portion of the payment of the charges for such services, or performing audits. In addition, I authorize Choice Diagnostic Imaging to request and obtain any necessary medical reports necessary for comparison purposes associated with my treatment.

_____ _____

Patient Signature *(Guardian/Parent If A Minor)* Date

CHOICE
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Patient Consent To The Use & Disclosure Of Health Information For Treatment, Payment, Or Healthcare Operations

PLEASE PRINT. THANK YOU!

I, _____, understand that as part of my health care, Choice Diagnostic Imaging originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among my healthcare providers,
- A source of information for business office and billing purposes,
- A means by which a third-party payer can verify that services billed were actually provided,
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals and a mechanism to communicate with persons regarding clinical research trials with which I participate.

I understand and have been provided with a Notice of Privacy Policies (Notice) that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry treatment, payment, or health care operations.

I understand that Choice Diagnostic Imaging is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Choice Diagnostic Imaging reserves the right to change their notice and practices, in accordance with Section 164.520 of the Code of Federal Regulations.

I wish to have the following restrictions on the use or disclosure of my health information:

_____

_____

_____

I understand that as part of this organizations treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and **accept / decline** the terms of this consent. (Circle **ONE**)

I authorize Choice Diagnostic Imaging to release information about my appointments, billing and/or financial information, and medical information to the following individuals:

CIRCLE ALL THAT APPLY: Spouse Parents Children Legal Guardian Grandparents

Other: _____
LIST BY NAME OR FACILITY NAME

Additionally, I authorize Choice Diagnostic Imaging to leave information concerning my appointments, billing or financial information, and medical information (strike through unacceptable options) on my answering machine/voice mail at the following phone number(s). I understand that receiving information regarding my health can be delayed if messages cannot be left.

_____ _____
PHONE NUMBER PHONE NUMBER

I understand that in order to revoke the authorizations above (except to the extent that the organization has already), I must request this revocation in writing to the Privacy Officer and that until such written document is received, this authorization will be followed.

_____ _____
PATIENT SIGNATURE *(GUARDIAN/PARENT IF A MINOR)* DATE

CHOICE
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Acknowledgement Of Receipt Of **"NOTICE OF PRIVACY PRACTICES"** *For Protected Health Information*

PLEASE PRINT. THANK YOU!

I acknowledge that I have received a copy of Choice Diagnostic Imaging's **"Notice of Privacy Practices"** for Protected Health Information on the date set forth below.

_____
Date of Receipt

_____
Print Patient Name

_____
If Under 18, Print Guardian/Parent Name

_____
Patient Signature *(Guardian/Parent If A Minor)*

FOR USE BY CHOICE DIAGNOSTIC IMAGING PERSONNEL ONLY

COMPLETE IF PATIENT ACKNOWLEDGEMENT IS NOT OBTAINED

An Acknowledgement of Receipt of Notice Of Privacy Practice was not obtained because:

☐ Patient refused to sign Acknowledgement

☐ Unable to gain signed Acknowledgement due to communication/language or other barrier

☐ Patient was unable to sign Acknowledgement due to communication/language or other barrier

☐ Other: Please include reason _____

_____

_____

_____ _____
Signature of Choice Diagnostic Imaging Representative Date

AUTHORIZATIONS/AGREEMENT

LIFETIME MEDICARE B SIGNATURE AUTHORIZATION: I authorize any holder of medical or other information about me to be released to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers, any information needed for this or related medicare claims. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party accepting assignment.

INSURANCE INFORMATION AUTHORIZATION: I authorize the release of any medical information necessary to process insurance claims. I further authorize payment of the medical benefits to Choice Diagnostic Imaging. I permit a copy of this authorization to be used in place of the original.

MEDICAL INFORMATION RELEASE AUTHORIZATION: I authorize the release of any medical information, records, diagnostic test results, or diagnostic images required for comparison of diagnostic tests performed by Choice Diagnostic Imaging or its affiliates. I permit a copy of this authorization to be used in place of the original.

I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT OF THIS BILL AND ALSO PAYMENT FOR INTERPRETATION OF THE STUDY. I ALSO UNDERSTAND THAT CHOICE DIAGNOSTIC IMAGING WILL FILE MY MEDICARE/INSURANCE AS A COURTESY TO ME. IF WORKERS COMPENSATION CLAIM IS DENIED, I WILL BE RESPONSIBLE FOR PAYMENT OF THIS BILL.

I ALSO UNDERSTAND AND AGREE IF BILLS ARE NOT PAID FROM THIRD PARTY SOURCES, THAT I AM RESPONSIBLE FOR PAYMENT OF THE BILLS. I ALSO AGREE TO BEAR THE COSTS OF COLLECTION OF ANY OUTSTANDING BILLS, INCLUDING REASONABLE ATTORNEY FEES AND ALL OTHER COSTS. I FURTHER AGREE TO GARNISHMENT OF EARNINGS GREATER THAN THE SUM SET FORTH IN SECTION 222.11; FLORIDA STATUTES, FOR PAYMENT OF BILLS OWED CHOICE DIAGNOSTIC IMAGING AND ITS AFFILIATES.

CONSENT FOR GENERALIZED CARE AND TREATMENT

I, the undersigned, hereby voluntarily consent to medical care and/or diagnostic treatment by Suncoast Diagnostic Inc., dba Choice Diagnostic Imaging employees and to the medical and diagnostic treatments as explained to me by the attending physician and whomever he or she may designate as his or her assistants. I am aware that the practice of medicine is not an exact science. I acknowledge that no guarantee has been made to me as the result of treatment or examination in the office. I authorize payment of medical benefits to Suncoast Diagnostic Inc., dba Choice Diagnostic Imaging and its physicians.

Patient Signature _____ Date _____

Guardian/Parent If A Minor _____ Date _____