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

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 ______________