CENTRAL IMAGING "OPEN" MRI

PATIENT INFORMATION

TODAY'S DATE: _____

PATIENT NAME: _____
LAST FIRST MIDDLE INITIAL

ADDRESS: _____ APT #: _____

CITY: _____ STATE: ____ ZIP: _____ EMAIL _____

HOME TELEPHONE #: _____ CELL PHONE #: _____

DATE OF BIRTH: _____ SOCIAL SECURITY #: _____ SEX: M F

EMPLOYER: _____ WORK #: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP _____

PRIMARY INSURANCE: _____ PHONE _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

POLICY #: _____ GROUP/PLAN #: _____

SECONDARY INSURANCE: _____ PHONE _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

POLICY #: _____ GROUP/PLAN #: _____

ATTORNEY'S NAME _____ PHONE _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

TELEPHONE #: _____ FAX #: _____

REFERRING PHYSICIAN: _____ TELEPHONE #: _____

DO YOU HAVE A FOLLOW-UP APPOINTMENT? IF YES, WHEN? _____

PRIMARY CARE PHYSICIAN: _____ TELEPHONE #: _____

WOULD YOU LIKE US TO SEND THIS IMAGING REPORT TO ANY OTHER DOCTOR NOT LISTED? _____

IS YOUR CONDITION RELATED TO:

EMPLOYMENT YES NO INJURY DATE: _____ CLAIM # _____

ACCIDENT YES NO INJURY DATE: _____ CLAIM # _____

SLIP & FALL YES NO

How did you hear about us? (Check all that apply) ___Biff Burger ___Gabber ___Physician ___Internet ___Seminole Beach/Beacon ___Yellow Pages ___Other

CENTRAL IMAGING OPEN MRI, INC

MEDICAL CONSENT: I consent to the examination, treatment, and procedures, which may be performed during the visit, including emergency treatment, considered necessary by my physician.

RELEASE INFORMATION: I authorize the above named provider to release any information needed to process the claims in reference to the examination, treatment, or procedures rendered by the provider. I further permit a copy of this authorization to be used in place of the original. I authorize the above named provider to request any information/records from other medical providers needed to help the process of my medical claim with Central Imaging Open MRI, Inc.

FINANCIAL RESPONSIBILITY: I understand that payment is due in full at the time of service and if not, I acknowledge that I am responsible to make the appropriate financial arrangements including but not limited to facilitating my insurance benefits and/or making monthly payment arrangements. Should my account become delinquent or be referred to any third party collection efforts, I agree to pay all reasonable interest, attorney fees, court costs and/or collection expenses. I agree in order for Central Imaging Open MRI, Inc. to collect any amounts I may owe, they may contact me by telephone at any telephone number associated with my account, including wireless telephone numbers, which could results in charges to me.

MEDICARE/MEDICAID BENEFITS ONLY: If applicable, I certify that the information given by me in applying for payment under Title XVIII and/or XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me, to release to the Social Security Administration or its intermediaries or carriers, any information needed to this or a related Medicare/Medicaid claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to Central Imaging Open MRI. I authorize the above named provider to submit to Medicare and/or Medicaid for payment on my behalf.

IRREVOCABLE PATIENT-ATTORNEY-HEALTHCARE PROVIDER LIEN (liability cases only): I authorize and direct my attorney to pay the above named provider directly and sums dues for medical services rendered to me. I direct my attorney to withhold such funds from any settlement, verdict or judgment that is rendered in my case. I hereby notify my attorney that I am giving the above named provider a lien on these benefits or settlement proceeds. In consideration for the above named provider waiting for payment, this lien is irrevocable and can be satisfied by full payment of all sums dues for medical services rendered. I authorize the above named provider to notify my attorney of this lien at the provider's discretion. I understand that any settlement, verdict or judgment proceeds cannot be disbursed to me without first satisfying this lien. Should a dispute arise regarding payment of my charges, I authorize and direct my attorney to hold all monies sufficient to satisfy this lien in escrow until the dispute can be resolved. I further understand that it would be a violation or my attorney's ethical duties to disburse these disputed funds prior to resolution to the lien dispute.

I have read this disclosure and I agree to the terms described above.

Patient Name (please print): _____ Date: _____

Patient Signature: _____

I, _____, have been informed of the Notice of Patient Privacy Practices made available by Central Imaging Open MRI, Inc.

Patient Signature: _____ Date: _____

ASSIGNMENT, LIEN AND AUTHORIZATION
INSURANCE BENEFITS

To Whom It May Concern:

I, _____ hereby authorize and direct you, my insurance company and/or my attorney, to pay directly to **Central Imaging Open MRI, Inc.** ("Assignee") such sums as may be due and owing Assignee for services rendered me, both by reason of accident or illness and by reason of any other bills that are due Assignee, and to withhold such sums from any disability benefits, medical payment benefits, No-Fault benefits, or any other insurance benefits obligated to reimburse me or from any settlement, judgment or verdict on my behalf as may be necessary to adequately protect said Assignee. I hereby further give a lien to said Assignees against any and all insurance benefits named herein and any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by Assignee. This is to act as an assignment of my rights and benefits to the extent of the Assignee's services provided. This assignment of benefits includes, but is not limited to, assignment of my right to file suit for non-payment and/or underpayment of insurance benefits. **Further, I hereby instruct the insurance carrier to request that, in the event the subject medical services and/or benefits are disputed for any reason, the amount of benefits being claimed by Central Imaging Open MRI, Inc. are to be held in escrow and not disbursed until the dispute is resolved.**

In the event my insurance company obligated to make payments to me upon the charges made by Assignee for their services refused to make such payments, upon demand by me or Assignee, I hereby assign and transfer to Assignee any and all causes of action that I might have or that might exist in my favor against such company and authorize Assignee to prosecute said cause of action either in my name or in Assignee name and further I authorize Assignee to compromise, settle or otherwise resolve said claim or cause of action as they see fit.

I authorize Assignee to release any information pertinent to my case to any insurance company, adjuster or attorney to facilitate collection under this Assignment, Lien and Authorization. I agree that the above mentioned Assignee be given Special Power of Attorney to endorse/sign my name on any and all checks and claim forms for payment of my bill.

Dated this _____ day of _____, 20_____

_____ _____

Claimant Witness

Central Imaging Open MRI, Inc.
AUTHORIZATION FOR RELEASE OF INFORMATION

PLEASE PRINT

Restrictions:

**Please tell us with whom we may discuss your protected health information: (Example: spouse (name), children (name(s)), other relatives (name(s)), friends or caregivers (names):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

** I request the following restriction to the use of disclosure of my health information:

_____

_____

_____

I understand that I may revoke this authorization at any time by notifying the practice in writing, but if I do, it won't have any effect on any actions they took prior to receiving the revocation.

_____ _____

Patient/Guardian Signature Date

_____

Print Name of Person Signing

*If other than the patient (Patient Name) _____ is signing, are you the legal guardian, custodian or have Power of Attorney for this patient for treatment, payment or healthcare operations? _____ Yes _____ No

Expires one year from date of signature

CENTRAL IMAGING "OPEN MRI"
6101 Central Avenue
St Petersburg, FL 33710
PHONE: (727) 381-4674 FAX: (727) 341-1182

CD/FILM/REPORT RELEASE AUTHORIZATION FORM

Date: _____ Exam(s): _____

Patient's Name: _____

Phone: _____ File#: _____

By taking possession of the following: (circle one) CD FILMS REPORTS

I, _____ hereby release Central Imaging "OPEN MRI" of any and all responsibility pertaining to the above stated items. This information is to be used for patient treatment, and will not be used as a basis for claims against the physician, hospital, or party releasing the same. **Films / CD do not need to be returned.**

Destination of Films: _____

Phone # of destination: _____

Address of destination: _____

_____
Patient Signature (or responsible party)

Notes:

_____

_____