Ocala Health
Advanced Imaging Centers

PATIENT INFORMATION

PLEASE PRINT CLEARLY ***TODAY'S DATE:*** _____

PATIENT NAME: _____
LAST ***FIRST*** ***MIDDLE***

DATE OF BIRTH: _____/_____/_____ ***SOCIAL SECURITY #:*** _____-_____-_____ ***SEX: M____ F____***

ADDRESS: _____
STREET ***CITY*** ***ST*** ***ZIP***

MAILING ADDRESS: _____
(IF DIFFERENT) ***CITY*** ***ST*** ***ZIP***

PHONE #: (_____) _____ ***CELL #*** (_____)_____

SPOUSE NAME: _____ ***SPOUSE DATE OF BIRTH:*** _____

EMERGENCY CONTACT NAME: _____ ***PHONE #:*** _____

REFERRING PHYSICIAN: _____

RESPONSIBLE PART OF ACCOUNT _____ ***SAME AS ABOVE (CHECK IF APPLICABLE)***

NAME: _____

DATE OF BIRTH: _____

SOCIAL SECURITY #: _____

ADDRESS: _____

PHONE NUMBER: _____

(Over →)

Authorization Information – Please Read Carefully

1. ***RELEASE OF INFORMATION:***

I authorize Advanced Imaging Centers and attending physician(s) to release any and all information acquired in the course of my examination and treatment in connection with Advanced Imaging Centers for the purpose of insurance, worker's compensation and / or Medicare benefit payments. I also request the release of any x-rays and/ or other radiologic films which are part of the records of Advanced Imaging Centers. I also authorize Advanced Imaging Centers to obtain any outside records pertaining to my exam.

2. ***ASSIGNMENT OF BENEFITS:***

I authorize payment directly to Advanced Imaging Centers and physicians(s) accepting this assignment of all services and medical benefits applicable and otherwise payable to me but not to exceed the reasonable and customary change for these services rendered by Advanced Imaging Centers and physician(s).

3. ***MEDICARE AND MEDICAID BENEFITS:***

Where Medicare and Medicaid benefits are applicable, I certify that the information given by me in applying for payment under Title XVIII 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 for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician(s) services to the physician(s) or organization furnishing the services, or authorize such physician(s) or organization to submit a claim to Medicare for payment to me.

4. ***FINANCIAL RESPONSIBILITY:***

All professional services rendered are charged to the patient. Necessary forms will be complete to help expedite insurance carrier payments. However, the patient is responsible for all fees regardless of insurance coverage. It is also customary to pay for services when rendered unless other arrangements have been made in advance with our office bookkeeper. I understand that I am responsible to Advanced Imaging Centers and physician(s) for reasonable charges incurred by me and not paid by third party benefits. In the event that the Advanced Imaging Centers bill or any party thereof, is deemed delinquent, I understand that I will be responsible for collection expenses as well as reasonable attorney's fees and court costs if suit is instituted.

5. ***RESPONSIBILITY FOR PERSONAL VALUABLES:***

I also understand that I am responsible for all articles (money, documents, radios, jewelry, dentures, eyeglasses, etc.) and/ or clothing which I retain in my possession (on my person) and for any other articles and/ or clothing which may be brought by me while I am having services rendered at Advanced Imaging Centers. I hereby release Advanced Imaging Centers physician(s) and any employees from any claim for loss of, damage to or complete destruction of such property.

6. ***CONSENT FOR TREATMENT:***

I, the below named patient, hereby give my consent for treatment to all radiologists and technicians associated with Advanced Imaging Centers

7. ***HIPAA NOTICE OF PRIVACY PRACTICES:***

My signature on this document acknowledges that I have received Advanced Imaging Centers HIPAA Notice of Privacy Practices.

The undersigned certifies that he or she has read and understands the foregoing and is the patient or is duly authorized by the patient as the patient's general agent to execute this form and accepts its terms (copy to patient upon request).

_____ _____

Patient Signature ***Date***

_____ _____

Patient's Agent or Representative (or Parent/ Legal Guardian if a Minor) ***Relationship to Patient***

_____

Witness

HIPAA Notice of Privacy Practices

Advanced Imaging Centers – Main • 2300 SE 17th Street, Suite 800 • Ocala, Fl. 34471 • (352) 867-9606
Advanced Imaging Centers – West • 8150 SW SR 200 • Ocala, Fl. 34481

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice of privacy practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information "is information about you, including demographic information that may identify you and that relates to your past, present or future physical or mental health or condition and related care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you , to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed , to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may use a sign-in sheet at the registration desk were you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Disease: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of section 164.500. Other Permitted and Required uses and Disclosures Will Be Made Only with Your Consent, Authorization or Opportunity to object unless required by law. Writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights:
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information: Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information: This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment or healthcare operation. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.
Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from use by alternative means or at alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints:
You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint.
We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at (352) 629-7979

Signature below or on your patient information sheet is only acknowledgement that you received this Notice of our Privacy Practices:

Print Name_____Signature_____Date_____

Please PRINT additional names that you would like to be able to have access to your records without your presence.

1. _____

2. _____