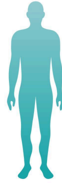

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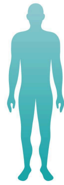
PATIENT INTAKE FORM

Name:		MRN:	
DOB:		Sex:		SS#:	
Mailing Address:			
Home Ph:		Mobile Ph:	
E-mail:			
EMERGENCY CONTACT INFORMATION			
Name:		Relationship:	
Phone:			
Referring MD:		Phone:	
Primary MD:		Phone:	
INSURANCE INFORMATION			
Primary Insurance Co:			
Policy/ID#:		Insured's Name/DOB:	
Insured's SSN:		Relation to Insured:	
Secondary Ins Co:		Policy/ID#:	
Insured's Name/DOB:		Insured's SSN:	
Law Firm Name:		Attorney Phone:	
Attorney Name (or Case Manager):			
IS THIS VISIT FOR TESTING DUE TO AN AUTO ACCIDENT/WORK RELATED INJURY? ☐ **YES** ☐ **NO**			
If so, please state **date of accident**:			

I understand that I am financially responsible for all charges whether or not paid by my insurance company. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions whether manual or electronic. I authorize any holder of medical information about me to release to the health care financing administration and its agent any information needed to determine these benefits or the benefits payable for related services. I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the hcfa form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer agency shown.

Patient Name:
Signature: ______________________________
Date:



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ASSIGNMENT OF INSURANCE BENEFITS, RELEASE & DEMAND, & AUTHORIZATION FOR TREATMENT

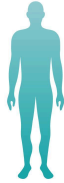
ASSIGNMENT OF BENEFITS AND RIGHTS: I HEREBY ASSIGN AND TRANSFER ANY AND ALL RIGHTS, BENEFITS AND CAUSES OF ACTION TO Summerlin Imaging center and its affiliates. This is an assignment of any rights and benefits. In the event my insurance company is obligated to make payment to me upon charges made by the Summerlin Imaging center and its affiliates for its services and the company fails or refuses to make timely, complete payment. I authorize Summerlin Imaging center and its affiliates to prosecute said cause of action either in my name Summerlin Imaging center and its affiliates name and further I authorize Summerlin Imaging center and its affiliates to compromise, settle or otherwise resolve said cause of action as they see fit.

DIRECTION OF PAYMENT: I hereby authorize and direct you, my insurance company and/or my attorney, to pay directly to Summerlin Imaging center and its affiliates, such sums as may be due and owing Summerlin Imaging center and its affiliates for the services rendered to me both by reason of accident or illness, and by reason of any other bills that are due Summerlin Imaging center and its affiliates. I hereby authorize any insurance company to pay directly to Summerlin Imaging center and its affiliates the amount of this and/or any future bills for services rendered to me and to release any information requested that is pertinent to my case to my insurance company or attorney Involved In this case.

LETTER OF PROTECTION IN FAVOR OF PROVIDER: I hereby authorize and direct that my lawyer, if I am represented by counsel, SHALL 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 reimburse Summerlin Imaging center and its affiliates for services provided to me. I HEREBY FURTHER GIVE AN IRREVOCABLE LIEN to said Summerlin Imaging center and its affiliates 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 Summerlin Imaging center and its affiliates. In the event that I do not have insurance coverage, I understand that I remain personally responsible for payment of services rendered. I also agree to pay in a current manner any difference between the total charges and the amount paid by the insurance company directly to Summerlin Imaging center and its affiliates.

PIP LOG & DEC SHEET REQUEST: I HEREBY AUTHORIZE Summerlin Imaging center and its affiliates TO REQUEST A COPY OF THE APPLICABLE INSURANCE POLICY AND DECLARATION PAGE WHICH REFLECTS THE POLICY LIMITS AVAILABLE AT THE TIME OF THIS ACCIDENT, AND THE APPLICABLE PIP LOG TO BE PROVIDED TO Summerlin Imaging center and its affiliates upon request. This request is authorized pursuant to the terms of my policy as well as Florida Statutes. I hereby authorize Summerlin Imaging center and its affiliates to request and receive a copy of my pip log periodically as they deem to be necessary.

RESERVATIONS OF BENEFITS: Be further advised that I AM HEREBY PLACING YOU ON NOTICE PURSUANT TO FLORIDA CASE LAW THAT SHOULD YOU (THE INSURANCE COMPANY/CARRIER) DENY, REDUCE OR FAIL TO PAY ANY PART OF, OR AN ENTIRE BILL WHICH WAS SUBMITTED ON MY BEHALF FROM THIS PROVIDER, I (THE ASSIGNOR) AS WELL AS Summerlin Imaging center and its affiliates ARE REQUESTING IN ADVANCE THAT YOU RESERVE, OR "SET-ASIDE," THE AMOUNT YOU REDUCED OR DENIED UNTIL THE DISPUTE IS RESOLVED. Should you submit a check to Summerlin Imaging center and its affiliates which is less than the correct contractual amount, and contains any language referring to payment as "Full and Final Payment," I have instructed Summerlin Imaging center and its affiliates to return the check to you (the carrier) and consider the bill still due and owing (i.e. a late payment as defined in F.S. 627.736). Additionally SHOULD THE REMAINING AMOUNT OF MY BENEFITS APPROACH AN AMOUNT WHERE THERE WOULD BE INSUFFICIENT FUNDS TO PAY THE AMOUNT YOU REDUCED, DENIED OR FAILED TO PAY, PLEASE NOTIFY ME (THE ASSIGNOR) AND Summerlin Imaging center and its affiliates OF THIS FACT. Should my benefits exhaust: please notify me (the assignor) and Summerlin Imaging center and its affiliates promptly.



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SEVERABILITY CLAUSE: If any term or provision of this Assignment, Lien and Authorization or the application thereof to any person or circumstances shall to any extent be invalid or unenforceable the remainder of this Assignment, Lien and Authorization, or the application of such term or provision to persons or circumstances other than those as to Which it is held invalid or unenforceable, shall not be affected thereby, and each term and provision of this Assignment, Lien and Authorization shall be valid and enforced to the fullest extent of the law.

CONSENT FOR MEDICAL AND SURGICAL TREATMENT: I authorize Summerlin Imaging Center and its affiliates to furnish the necessary medical or surgical treatments, or procedures, including diagnostic x-ray, laboratory procedures, contrast injection, and/or drugs. I also authorize the attending physician(s), his assistants, or his designees to order supplies as needed. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as to the results of treatment/diagnostic procedures in Summerlin Imaging Center and its affiliates. I recognize that the physician(s) who practice at Summerlin Imaging Center and its affiliates are not employees of Summerlin Imaging Center and its affiliates but are independent physicians. Summerlin Imaging Center and its affiliates may delegate to these independent physicians those services physicians normally provide; any questions relating to care which physician has given or ordered should be directed to him/her.

RELEASE OF INFORMATION: I hereby authorize the Provider and the Assignee to furnish an insurer, an insurer's intermediary, and my attorney via mail, fax, or email, with any and all information that may be contained in the medical records; to obtain insurance coverage information in writing (declaration sheet) and telephonically from the insurer; request from any insurer all explain of benefits (EOBs) for all providers and non-redacted PIP payout sheets; obtain any statements the patient provided to the insurer; obtain copies of all medical records, X-Rays, IMES, and MRIs from any other medical provider or any insurer. The Provider and Assignee may produce my medical records to its attorney in connection with any pending lawsuits. The insurer is directed to keep my medical records private and confidential and is not authorized to provide these medical records to anyone without my prior express written permission.

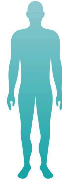
CERTIFICATION: I certify that I have read and agree to the above.

CAUTION: Please read before signing. If you do not completely understand this document, please ask us to explain it to you. If you sign below, we will assume you understand and agree to the above.

Patient Name: **Date**:

Patient Signature: ____
(if patient is minor, signature of parent/guardian)

EMPLOYEE INITIALS: __________



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DISCLOSURE OF PROTECTED HEALTH INFORMATION

By law, medical information is confidential unless written authorization is given. This form is designed for you, the patient, to specify exactly whom you **do** and **do not** want to receive medical information pertaining to your care at our facility.

I authorize Summerlin Imaging Center and its affiliates to give medical information to the following persons:

***The information requested is for personal family and/or friends, NOT the referring physician.**

Name & Relationship

Name:	Relationship:
Name:	Relationship:

☐ I request that you **DO NOT** disclose medical information to anyone other than myself.

☐ I prefer that my medical information should **NOT** be released to the following person(s):

Name:	Relationship:
Name:	Relationship:

,

***Please note, unless otherwise specified, the referring physician is authorized to receive a copy of your report.**

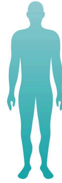
☐ Do / ☐ Do not leave messages on answering machine or voicemail.
☐ Do / ☐ Do not call me at home.
If not, please provide alternate telephone contact info: ______________________________

☐ Do / ☐ Do not call me at work.
☐ Do / ☐ Do not mail statements or other correspondence to my home. If not, please
Provide alternate mailing address: ______________________________

This remains in effect until I give written notification to discontinue or change.

Patient Signature: ______________________________ Date: ____________________

Parent/Guardian of minors under age 18 has access to medical records, apart from any State Law protecting the privacy of information of minors.



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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

Jacksonville Diagnostic Imaging known as Park Avenue Imaging will use and disclose your personal information to treat you. To receive payment for the care we provide, and for other health care operations.
Healthcare operations general include those activities we perform to improve the quality of care.

We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies about your personal health information.
The terms of the notice may change with time and we will always post the current notice at our facilities, on our website, and have copies available for distribution.

Patient Name:

Signature: ____

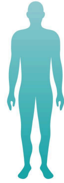
Date:

For Office Use Only

We attempt to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but the acknowledgement could not be obtained because:

☐ Individual refused to sign
☐ Communication barriers prohibited obtaining the acknowledgement
☐ An emergency situation prevented us from obtaining acknowledgement
☐ Other (Please Specify)

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT
Include completed consent in the patient's Medical Record



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E-MAIL CONSENT FORM

The LLC and its staff members shall be referred to throughout this consent form as "provider".

Patient Name:___________________________________ **DOB:**_______________________

Patient E-mail address:____

Patient phone number: ___________________________ **Decline E-mail Consent:** ______

(Please initial if you are declining E-mail consent)

1. RISK OF USING E-MAIL TO COMMUNICATE WITH YOUR PROVIDER:
Provider offers patients the opportunity to communicate by e-mail. Transmitting patient information by e-mail has a number of risks that patients should consider before using e-mail communication. These include, but not limited to, the following risks:

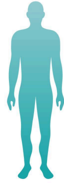
a, E-mails can be circulated, forward, and stored in numerous paper and electronic files.
b. E-mails can be immediately broadcast worldwide and be received by unintended recipients.
c. E-mail senders can easily type in the wrong email address.
d. E-mail is easier to falsify handwritten or signed documents.
e. Backup copies of e-mail may exist even after the sender or recipient has deleted his or her copy.
f. Employers and on-line services have a right to archive and inspect e-mails transmitted through their system.
g. E-mail can be intercepted, altered, forward, or used without authorization or detection.
h. E-mail can be used to introduce viruses into the computer system.
i. E-mail can be used as evidence in court.

2. CONDITIONS FOR THE USE OF E-MAIL:
Provider will use reasonable means to protect the security and confidentiality of e-mail information sent and received. However, because of the risks outlined above, provider cannot guarantee the security and confidentiality of e-mail communication, and will not be liable for improper disclosure of confidential information that is not caused by provider's intentional misconduct. Thus, the patients must consent to the use of e-mail for patient information. Consent to the use of e-mail includes agreement with the following conditions.

a. All e-mails to or from the patient concerning diagnosis or treatment will be printed out and made part of the patient's medical record. Because they are part of the medical record, other individuals authorized to access the medical records will have access to those e-mails.
b. Provider may forward e-mails internally to provider's staff and agent necessary for diagnosis, treatment, reimbursement, and other handling. Provider will not, however, forward e-mails to independent third parties without the patient's prior written consent, except as authorized or required by law.
c. The patient is responsible for protecting his/her password or other means of access to e-mail. Provider is not liable for breaches of confidentiality caused by the patient or any third party.
d. Provider shall not engage in e-mail communication that is unlawful, such as unlawfully practicing medicine across state lines.
e. It is the patient's responsibility to follow-up and/or schedule an appointment.

3. PATIENT RESPONSIBILITIES AND INSTRUCTIONS:
To communicate by e-mail, the patient shall:

a. Limit or avoid using his/her employer's computer.
b. Inform provider of changes in his/her e-mail address.
c. Confirm that he/she has received and read the e-mail from the provider.
d. Put the patient's name in the body of the e-mail.
e. Include the category of the communication in the e-mail subject line, for routing purposes (e.g. billing and questions).
f. Take precautions to preserve the confidentiality of e-mail, such as using screen savers and safeguarding his/her computer password.
g. Withdraw consent only by e-mail or written communication to provider.



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TERMINATION OF THE E-MAIL RELATIONSHIP.

The provider shall have the right to immediately terminate the e-mail relationship with you if determined in the sole provider's discretion, that you have violated the terms and conditions set forth above or otherwise breached this agreement, or have engaged in conduct which the provider determines to be unacceptable.

PATIENT ACKNOWLEDGEMENT AND AGREEMENT

I have discussed with the provider his/her representative and I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of e-mail between the provider and me, and consent to the conditions herein. I agree to the instructions outlined herein, as well as any other instructions that my provider may impose to communicate with patients by e-mail. Any questions I may have had were answered.

Patient Name (print):____

Patient Signature:____

Date:________________________________