

Please check the appropriate facility :

IMAGING CENTER AT FORBES,LLC  
904 391 1600 (PH) \* 904 391 1605 (FAX)

IMAGING CENTER AT LAKEWOOD,LLC  
904 448 2296 (PH) \* 904 448 2298 (FAX)

Please complete the enclosed forms and fax to 904-391-1605 with a copy of your insurance card (front and back) prior to your appointment. If you are unable to fax the forms prior to your appointment, please bring them with you to your appointment. This will help expedite the check in process.

Please arrive 15 minutes early to your appointment so that we can verify your information.

If you are unable to keep your scheduled appointment, please call the office as soon as possible to cancel or reschedule.

Please take the time to look at our website, as this will answer many questions about your exam. If you have any further questions, do not hesitate to call our office, we are here for you! At Imaging Center Network we are "Putting Our Patients First!"

We look forward to your visit with our office.

Imaging Center at Forbes, LLC  
Imaging Center at Lakewood, LLC

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# **Patient's Rights and Responsibilities**

As a patient of Imaging Center at Forbes, LLC, and/or Imaging Center of Lakewood, LLC, you have certain rights and responsibilities. Imaging Center Network recognizes that a respectful relationship between Imaging Center Network and the patient is the foundation of proper care. Copies of this statement are posted in our waiting room.

Patients have the right to:

- Receive humane care and treatment, with respect and consideration.
- Privacy and confidentiality when seeking or receiving care except for life threatening conditions or situations.
- Confidentiality of your health records
- Be informed of and to exercise the option to refuse to participate in any research aspect of your care without compromising access to medical care and treatment
- Receive accurate information concerning diagnosis, treatment, risks involved, and prognosis of an illness or health related condition (Please Note: Your Referring Doctor provides all information regarding your study and is responsible for explaining the findings of the study.)
- Ask about reasonable alternatives
- A second professional opinion regarding study
- Participate actively in decisions regarding one's health care and treatment
- Accessible information regarding the scope and availability of services
- Be informed about any legal reporting requirements regarding any aspect of studies or care

Patients have the responsibility to:

- Provide complete information about one's illness/problem, to enable proper screening
- Ask questions so that an understanding of the study is ensured
- Show respect to health personnel and other patients
- Reschedule/cancel an appointment so that another person may be given that time slot
- Pay bills or file health claims in a timely manner
- Inform technologist(s) if any unusual reaction occurs during study

**PATIENT REGISTRATION**

Imaging Center at **Forbes**, LLC  Imaging Center at **Lakewood**, LLC

SOCIAL SECURITY # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ SEX \_\_\_\_\_

NAME \_\_\_\_\_

HOME ADDRESS \_\_\_\_\_ FIRST \_\_\_\_\_ MIDDLE \_\_\_\_\_ LAST \_\_\_\_\_ APT / UNIT \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

HOME PHONE \_\_\_\_\_ MARITAL STATUS (CHECK ONE)

WORK PHONE \_\_\_\_\_  Single  Married  Separated  Divorced  Widowed

CELL PHONE \_\_\_\_\_ REFERRING PHYSICIAN \_\_\_\_\_

EMPLOYER \_\_\_\_\_ DATE OF INJURY \_\_\_\_\_

LIST SYMPTOMS / PROBLEMS RELATED TO TODAY'S TEST \_\_\_\_\_

**INSURANCE INFORMATION - PLEASE PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST**

Commercial  Medicare  Medicaid  Worker's Compensation  Attorney  Other

**PRIMARY** INSURANCE COMPANY \_\_\_\_\_ PHONE \_\_\_\_\_

INSURED / CARD HOLDER'S NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

POLICY # \_\_\_\_\_ GROUP # \_\_\_\_\_

Commercial  Medicare  Medicaid  Worker's Compensation  Attorney  Other

**SECONDARY** INSURANCE COMPANY \_\_\_\_\_ PHONE \_\_\_\_\_

INSURED / CARD HOLDER'S NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

POLICY # \_\_\_\_\_ GROUP # \_\_\_\_\_

**ATTORNEY INFORMATION**

ATTORNEY NAME \_\_\_\_\_ PHONE \_\_\_\_\_

FIRM \_\_\_\_\_ CONTACT NAME \_\_\_\_\_

**GUARANTOR / RESPONSIBLE PARTY**

SOCIAL SECURITY # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ SEX \_\_\_\_\_

NAME \_\_\_\_\_

TELEPHONE: HOME \_\_\_\_\_ FIRST \_\_\_\_\_ MIDDLE \_\_\_\_\_ LAST \_\_\_\_\_ WORK \_\_\_\_\_ CELL \_\_\_\_\_

**EMERGENCY CONTACT**

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

TELEPHONE: HOME \_\_\_\_\_ FIRST \_\_\_\_\_ LAST \_\_\_\_\_ WORK \_\_\_\_\_ CELL \_\_\_\_\_

**Assignment of Benefits:** I hereby authorize and assign all payments and/or insurance benefits for services rendered, directly to Imaging Center Network. I agree to issue payment to Imaging Center Network the event I receive payment for Imaging Center Network services. I understand I am financially responsible for all charges not covered by my insurance plan.

PRINT PATIENT NAME \_\_\_\_\_

SIGNATURE OF PATIENT \_\_\_\_\_

DATE \_\_\_\_\_

RELATIONSHIP TO PATIENT:

PARENT  GUARDIAN

PRINT NAME OF PARENT, GUARDIAN OR LEGAL REPRESENTATIVE \_\_\_\_\_

SIGNATURE OF PARENT, GUARDIAN OR LEGAL REPRESENTATIVE \_\_\_\_\_

OTHER LEGAL REPRESENTATIVE \_\_\_\_\_

# Patient Registration Agreement

Imaging Center at Forbes, LLC

Imaging Center at Lakewood, LLC

**PATIENT NAME:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Imaging Center appreciates the confidence you have shown in choosing us to provide your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect this payment at time of service; many insurance companies have additional stipulation that may affect your coverage. If your insurance carrier denies any part of your claim, or the insurance company fails to pay Imaging Center in a timely manner, you will be responsible for your balance in full. You understand you are responsible for prompt payment of all amounts owed to Imaging Center. Should your account be referred to a collection agency or attorney for collection, the undersigned shall pay all costs of collection, including any collection fees, attorney's (including paralegals and legal assistants) fees and expenses, court costs, including any such fees, expenses and/or costs on appeal.

In addition, in the event a payment is received by the patient from the insurance carrier for services rendered by Imaging Center, you agree to issue payment to Imaging Center.

I have read the above policy regarding my financial responsibility to Imaging Center, for diagnostic radiology services to me or the above mentioned patient. I certify the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Imaging Center, the full and entire amount of bill incurred by me or the above named patient; or, if applicable any amount due after payment has been made by insurance carrier.

Imaging Center accepts payment in cash, checks and credit cards. I understand additional charges are applied to my account for returned check.

## **Letter Of Protection**

As a courtesy to you, Imaging Center may have accepted a Letter Of Protection from your attorney. This agreement is for the period of one year and will expire after one year. In the event the case has not settled, still in litigation, the attorney no longer represents you, the attorney has not provided a status of the case, and or a balance is due Imaging Center, you are responsible for payment of the entire balance upon demand.

## **Consent for Treatment**

I hereby authorize Imaging Center, through its appropriate personnel, to perform or have performed upon me, or the above named patient, appropriate assessment and treatment procedures.

**BY SIGNING THIS AGREEMENT, I ACKNOWLEDGE THAT I HAVE CAREFULLY READ, UNDERSTOOD AND AGREED TO THE ABOVE TERMS AND CONDITIONS.**

\_\_\_\_\_  
PRINT PATIENT NAME

\_\_\_\_\_  
SIGNATURE OF PATIENT

\_\_\_\_\_  
PRINT NAME OF PARENT, GUARDIAN  
OR LEGAL REPRESENTATIVE

\_\_\_\_\_  
SIGNATURE OF PARENT, GUARDIAN  
OR LEGAL REPRESENTATIVE

DATE: \_\_\_\_\_

DATE: \_\_\_\_\_

## **RELATIONSHIP TO PATIENT:**

PARENT       GUARDIAN

OTHER LEGAL REPRESENTATIVE      DESCRIBE: \_\_\_\_\_



**AUTHORIZATION TO RELEASE AND SHARE INFORMATION**

I hereby authorize my individually identifiable health information to be entered into the Imaging Centers' electronic databases and shared with their authorized healthcare staff to be used and disclosed in accordance with Imaging Centers' Notice of Privacy Practices, including (i) disclosure to my insurer/third-party carrier and past, present and future healthcare providers, and (ii) obtain and use information (including information related to mental health, substance abuse, HIV/AIDS, and sexually transmissible diseases) from and copies of my medical records maintained by any other past or present healthcare providers (or their respective records custodians) for healthcare treatment, payment, operations, or otherwise, or, to the extent permitted by applicable law. My information will remain confidential and will not be used for marketing or solicitation purposes – or shared with any persons outside of Imaging Centers – without additional written authorization from me. However, I understand that the information used and/or disclosed according to this authorization may no longer be protected by federal privacy law (also known as HIPAA) and the recipient of my health information may potentially redisclose it. I understand that I can refuse access to part or all of my information, at any time, by a written statement. If I choose not to give my consent, my refusal will not prevent me from receiving healthcare services Imaging Centers.

**RELEASE FROM LIABILITY**

I HEREBY RELEASE IMAGING CENTERS FROM ANY AND ALL LEGAL LIABILITY THAT MAY ARISE FROM THE DISCLOSURE OF MY INFORMATION, INCLUDING INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

**SPECIAL AUTHORIZATION TO DISCLOSE SUPER-CONFIDENTIAL INFORMATION**

**ALCOHOL/DRUG/INFECTIOUS DISEASE/MENTAL HEALTH RECORDS** are protected by Federal Regulation 42 CFR, Part 2. Release of such records requires specific consent. I hereby grant such specific consent as initialed below. **I UNDERSTAND THAT THESE RECORDS ARE PROTECTED UNDER FEDERAL AND STATE LAW AND CANNOT BE DISCLOSED WITHOUT MY WRITTEN CONSENT UNLESS OTHERWISE PROVIDED BY LAW. I FURTHER UNDERSTAND THAT THE SPECIFIC TYPE OF INFORMATION TO BE DISCLOSED MAY, IF APPLICABLE, INCLUDE DIAGNOSIS, PROGNOSIS, AND TREATMENT for physical and/or mental illness including treatment of alcohol or substance abuse, sexually transmitted diseases, acquired immune deficiency syndrome (AIDS), or human immunodeficiency virus (HIV) infection. AS PART OF THE MEDICAL RECORDS CHECKED ABOVE, THE FOLLOWING INFORMATION WILL BE RELEASED UNLESS CROSSED OUT:**

- HIV/AIDS related information and/or records
- Sexually transmitted diseases
- Drug/alcohol diagnosis, treatment/referral information
- Mental Health information and/or records

\_\_\_\_\_  
Client or Legal Representative

DATE: \_\_\_\_\_

**EXPIRATION AND RIGHT TO REVOKE AUTHORIZATION**

I UNDERSTAND THAT THIS AUTHORIZATION WILL **EXPIRE ONE YEAR FROM TODAY'S DATE**. I MAY REVOKE THIS AUTHORIZATION AT ANY TIME, IN WRITING, BEFORE THE INFORMATION HAS BEEN RELEASED. I FURTHER UNDERSTAND THAT I HAVE A RIGHT TO RECEIVE A COPY OF THIS AUTHORIZATION UPON REQUEST.

**SIGNATURE**

**BY SIGNING THIS AGREEMENT, I ACKNOWLEDGE THAT I HAVE CAREFULLY READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS OF THIS AUTHORIZATION, AND THE IMAGING CENTER'S NOTICE OF PRIVACY PRACTICES..**

**PATIENT Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**Parent, Guardian or Legal Representative Signature:** \_\_\_\_\_  
**Printed Name of Parent, Guardian or Legal Representative:** \_\_\_\_\_  
**Relationship to Client:** \_\_\_\_\_

**AFTER SIGNATURE AND UPON REQUEST, YOU ARE ENTITLED TO RECEIVE A COPY OF THIS AUTHORIZATION.**

**MEDICAL RECORDS AUTHORIZATION TO RELEASE**

**Medical Records Authorization to Release**

I authorize Imaging Center Network to release my report (s) to the following: (Please provide Doctors Names)  
Imaging Center Network will only release your report to your referring doctor unless specifically requested by you. Please Indicate and provide Doctors name of which you authorize Imaging Center Network to release your report (s), films, and or CD.

**Primary Doctor-** \_\_\_\_\_

**Specialists-** \_\_\_\_\_

**Please note: Unless signed and specified as above, your records will not be released without your signed consent.**

**Authorization for Imaging Center Network to Obtain Previous Reports/Studies**

If you have had a previous study similar in nature to a study you are scheduled for, Imaging Center Network must obtain previous reports and or studies needed for comparison. I authorize Imaging Center Network to obtain report, films, and or CD from:

**Facility Name/:** \_\_\_\_\_

**IDENTIFYING INFORMATION AT THE TIME OF SERVICE**

\_\_\_\_\_  
PATIENT'S FULL NAME

\_\_\_\_\_  
PATIENT'S SOCIAL SECURITY NUMBER

\_\_\_\_\_  
ADDRESS

\_\_\_\_\_  
PATIENT'S DATE OF BIRTH

\_\_\_\_\_  
CITY, STATE, ZIP

\_\_\_\_\_  
PATIENT'S PHONE NUMBER

I understand that disclosure of the information in this medical record may include information relating to mental illness, HIV related illness, AIDS, and or drug or alcohol treatment.

I understand that this authorization may be revoked in writing providing the information has not already been disclosed. I may revoke this authorization by written notification.

I understand I may be charged for copies of this information in accordance with Florida law.

I understand that once the information is disclosed, the information is subject to redisclosure and may no longer be protected by the federal privacy regulations.

I understand the matters discussed on this form. I release the provider, its employees, officers, directors, medical staff members, and business associates from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

\_\_\_\_\_  
Signature of Patient or Patient's Representative

\_\_\_\_\_  
Relationship (if not patient)

\_\_\_\_\_  
DATE

\*If a personal representative of the patient signs the authorization, please indicate his or her authority to act.