Assignment of Insurance Benefits:

Pregnancy Consent (Not applicable to Ultrasound studies and ONLY for female patients)

The purpose of this statement is to inform Diagnostic Medical Imaging, that I do not believe I am pregnant at this time and therefore agree to have the study requested by my physician. The effects of radiation generated during the course of any studies are unknown to an unborn child, we must ask the following questions on this form regarding pregnancy, no matter how remote the possibility. Your candor and cooperation on this matter is absolutely necessary.

Date of Last Menstrual period:_____**Are you pregnant ?** _____ YES _____NO

Si usted esta embarazada, las pruebas de radiografias diagnosticas pueden poner en peligro a las criaturas en qualquier momento durante el embarazo. Por favor avisenos si usted podria estar embarazada.

Fecha de su Ultima Menstruacion:_____**Esta Embarazada**?_____SI _____NO

I request that payment of authorized insurance benefits, including Medicare, if I am a Medicare beneficiary, be made on my behalf to Diagnostic Medical Imaging of Hollywood , for any equipment or services provided to me by this organization. I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related equipment or services to Center for Medicare and Medicaid Services (CMS), my insurance carrier or other medical entity. A copy of this authorization will be sent to the CMS, my insurance company or other entity if requested. I understand that I am financially responsible to the Organization for any charges not covered by health care benefits. It is my responsibility to notify the organization of any changes in my health care coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the organization and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form I am accepting financial responsibility as explained above for all payment for products received. If this account becomes past due, or is referred for collections, which may include, but not be limited to, late fees of up to 1.5% of any outstanding monthly balance, court cost and reasonable attorney's fees. By signing this document, I also acknowledge that I have received a copy of the organization's Notice of Privacy Practices. This acknowledgement is required by the Health Insurance Portability and Accountability Act (HIPAA) to ensure that I have been made aware of my privacy rights.

Solicito que el pago de las prestaciones de seguros autorizadas, incluyendo Medicare, si soy un beneficiario de Medicare, se hagan en mi nombre a Diagnostic Medical Imaging,of Hollywood, LLC A MD, por cualquier equipo o servicios de que se me por esta organización. Yo autorizo la divulgación de cualquier información médica necesaria para determinar estos beneficios o los beneficios pagaderos para el equipo o servicios relacionados con los Centros de Medicare y Medicaid (CMS), mi compañía de seguros o entidad médica. Una copia de esta autorización será enviada a la CMS, mi compañía de seguros u otra entidad si así lo solicita. Yo entiendo que soy financieramente responsable de la Organización de los cargos no cubiertos por las prestaciones de salud. Es mi responsabilidad notificar a la organización de cualquier cambio en mi cobertura de salud. En algunos casos los beneficios exactos de seguros no se puede determinar hasta que la compañía de seguros recibe la reclamación. Yo soy responsable de toda la factura o el saldo de la cuenta según lo determinado por la organización y / o mi compañía de seguros de salud si las reclamaciones presentadas o cualquier parte de ellos se les niega el pago. Entiendo que al firmar este formulario estoy aceptando la responsabilidad financiera como se ha explicado anteriormente para el pago de todos los productos recibidos. Si esta cuenta se vence, o se hace referencia para las colecciones, que pueden incluir, pero no limitado a, cargos por pagos atrasados de hasta el 1,5% de cualquier saldo pendiente de pago mensual, el costo de la corte y honorarios razonables de abogados. Al firmar este documento, yo también reconozco que he recibido una copia de la Notificación de la organización de prácticas de privacidad. Este reconocimiento es requerido por la Health Insurance Portability and Accountability Act (HIPAA) para asegurarse de que he sido informado de mis derechos de privacidad.

Name / Nombre: _____ **Signature / Firma:_____**

Date / Fecha: _____

Witness Name: _____ Signature: _____

Date: _____

AUTHORIZATION OF THE USE OF DISCLOSURE OF MEDICAL RECORDS

NAME: _____ Date of Birth ____/___/_____
(**NOMBRE Y APELLIDO**) (**FECHA DE NACIMIENTO**)

I authorize DMI, LLC officer, employees, agents, contractors, members, director and shareholders or affiliates entrusted with handling medical records for DMI to disclose the transcribed report and other related health care information to:

Yo autorizo a DMI, directores LLC, empleados, agentes, contratistas, socios, accionistas o director y filiales encargadas de la manipulación de los registros médicos de DMI para divulgar el informe transcrito y otra información relacionada con el cuidado de salud para:

1.) Doctor Last Name:_____ Doctor First Name:_____

Address:_____

City:_____ State:_____ Zip Code:_____

2.) Doctor Last Name:_____ Doctor First Name:_____

Address:_____

City:_____ State:_____ Zip Code:_____

3.) Doctor Last Name:_____ Doctor First Name:_____

Address:_____

City:_____ State:_____ Zip Code:_____

The Protected Health Information (P.H.I.) may be used, disclosed or received for the following purpose (s):

If you do not wish to describe the purpose, then you may insert: “upon request”
Unless otherwise revoked, this authorization shall remain in effect until: _____

I acknowledge the following:

1. I have the right to revoke this authorization at any time by sending written notification to DMI, LLC.
2. Any information disclosed pursuant to this authorization to an individual or entity that is not covered by the state and federal privacy laws and regulations may be subject to re-disclosure by the recipient may no longer be protected by federal or state law.

_____ ____/_____/_____
Signature / Firma **Date / Fecha**