DIAGNOSTIC MEDICAL IMAGING OF HOLLYWOOD

6517 TAFT STREET SUITE 103
HOLLYWOOD FLORIDA 33016
TEL: 954-780-5566 FAX: 954-780-5567

Personal Information:

Name: (Nombre) **Date:** (Fecha)

Date of Birth: (Fecha de Nacimiento) **Age:** (Edad) **Social Security #:** (Numero de Sueguro Social)

Address: (Direccion) **Apt:** (Apartamento)

City: (Ciudad) **State:** (Estado) **Zip Code:** (Codigo Postal)

Home #: (Numero de Casa) **Work#:** (Numero de Trabajo)

Cell#: (Celular) **Sex:** F (Sexo) **Marital Status:** S M W Sep D (Estado Civil)

Emergency Contact: **Telephone #:**

Medical Providers: Primary Doctor: Telephone #

Referring Physician: Telephone #

Employer Information: Employer Name __________________________________ Telephone #:___________________

Primary Insurance: *Type (circle one): HMO PPO MEDICARE MEDICAID W/C*

Name: **Authorization#:**

ID#: **Authorization#:** ______________________________

Secondary Insurance: *Type (circle one): HMO PPO MEDICARE MEDICAID W/C*

Name: **Co-Pay Amount PAID:** $______________________

ID#: **Form of Payment:** C/C Check # _______ Cash

Medical Center Policies:

A. Please alert our office of any insurance or address changes.
B. If you are on HMO or on an insurance company that requires authorization for your test, please make sure the authorization has been received.
C. It is your responsibility to know if your insurance has specific rules or regulations, such as the need for referrals from a physician, pre-certification, and limits on outpatient charges. You should be knowledgeable of any deductibles, co-payments, and/or coinsurance. The responsibility for payment of fees for services is the direct responsibility of the patient.
D. If you do not wish to wait for your authorization, ask our staff about our self-pay prices.
E. Your health benefit plan is an arrangement between you, the enrollee and the insurance company, HMO or your employer. Your health benefit plan determines your coverage, requirements, and establishes the limit on your coverage for medical services based on what they determine is medically necessary. However, we will do our best to assist you with understanding your proposed treatment and in answering questions related to your insurance.
F. All results will be sent to your referring physician within 48-72 hours.
G. Co-payments and deductibles are due at the time of service.

Patients with input or comments, please feel free to write to us at 6517 Taft St., Suite 103, Hollywood, FL 33024

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 retain 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**

Your Rights

Right to inspect or copy your PHI: Under federal law, however, you may not inspect or copy 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.

Right to request restriction of your PHI: You may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or operations. 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 be in writing and must state the specific restrictions requested and to whom you want the restrictions to apply. The facility is not required to agree to a restriction that you may request. If the Medical Director or his appointees believe it is in your best interest to permit use and disclosure of your protected health information, your PHI will not be restricted.

Right to alternative communications: You have the right to request to receive confidential communications from us by alternative means or at an alternative location.

Right to obtain a paper copy: Upon request, even if you have agreed to accept this notice alternatively, i.e., electronically.

Right to amend your PHI: The facility has the right to deny your amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

Right to accounting disclosures: 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.

You may complain to us or to the Secretary of the Department 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, 2004.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respects 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 our main phone number.

Signature below is only acknowledgement that you have received this Notice of Privacy Practices.

______________________	______________________	____________
Print Name	Signature	Date