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Patient Information Date: ______________________

Patient Name: __________________________________ DOB: _____________________________

Address: ____ Phone: ____________________________

Sex: Male Female Weight: _______ Female Patients: Pregnant Yes No Last Menstrual Cycle: _______

With full understanding of the above, I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at the time and I wish to have a radiographic examination performed now. There is a risk of radiation and the possibility that it will harm a fetus; thus, if there is a chance that you are pregnant, you should not participate in the study before having a test to confirm non-pregnancy. Initials _______.

Check if you have ever had any of the following:

Heart Disease Diabetes Tattoo/Permanent Makeup Hypertension/High Blood Pressure

Cardiac Pacemaker Metal Implants in your Body Asthma or Respiratory Disease Heart Surgery

Removable Dental Work Shrapnel/Fragments Brain Aneurysm Clip Electrical Stimulator Renal (Kidney) Disease

Allergic Reaction to: Contrast / Iodine / Shellfish

Cancer History: ____

Prior Surgeries (Type & Date): ____

Are you currently taking Metformin? Yes No Glucophage? Yes No

Prior Exams related to today's study (Facility name, date, exam type):

____

____

Contrast Patients Only

- You may be receiving an intravenous contrast media and/or oral contrast media to enhance the visibility of certain tissues. Possible side effect include, but are not limited to: nausea, a warm flushed feeling, potential allergic reaction (including but not limited to: hives, wheezing, difficulty breathing in rare cases, anaphylactic shocks) Initial: ___________
- I, the undersigned, verify that all the answers I have provided are true to the best of my knowledge. I give Centers For Imaging LLC the permission to perform the examination(s) as requested by my Physician. I have read the above and fully understand its contents and all my questions have been answered.

Signature: ______________________________________ Date: ____________

______________________________ **Do Not Write Below this Line** ______________________________

EMR Completed: Yes/______ MVA or DOI: ___________ Contrast: ______________

Previous Reports: ____

Exam Type: MRI DMX Xray Fluoroscopy

Dx: ____

Symptoms: ____

____

Radiologist: ____________________ Tech: _____________________ Priors: _______________________

Comments: ____

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Patient Compliance Form

This information is for Electronic Medical Records in compliance with the new Medi care regulations. Centers For Imaging LLC is in compliance with all confidentiality laws under the Health Insurance Portability and Accountability Act (HIPAA).

Patient Name: ___________________________________ Account: _____________ Date: ____________

Sex: Male Female

Language: English Spanish Other: ________________

Race: American Indian/ Alaskan Native Hawaiian or Pacific Islander Asian Caucasian

Black or African American Refuse to Answer Other: __________________

Ethnicity: Hispanic or Latino Non-Hispanic or Latino Other: __________________

Do you currently smoke? Yes No

List any know Allergy or Medication:

____

____

Medical History or Symptoms non-related to today's visit:

____

____

Current Medications you are taking:

____

____

Centers For Imaging is owned and operated by Integrative Physical Medicine Holding, LLC. Any and all patients referred from any Integrative Physical medicine location have the right to choose an imaging center of choice.

Release of Centers For Imaging LLC Records (Requires at least 48 hours)

I hereby authorize Centers For Imaging LLC to release my information and/or copies of my medical records to any of the guarantor payment on my account, any insurance company for which benefits have been assigned, and/or to the person(s) listed below:

1. Name: ______________________________ Relationship: ___________________________
2. Name: ______________________________ Relationship: ___________________________
3. Name: ______________________________ Relationship: ___________________________

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Patient Name: ____

Date of Birth: ____________________________ Social Security: ____________________________

Guarantor Name: __________________________________

Emergency contact: _______________________________ Relation: ____

Address: ____ City/State: _________________ Zip: _________________

Phone: ________________________ Cell: _______________________ Work/Other: __________________________

Referring Office/Doctor: __________________________________

Auto Insurance: _______________________________________ Health Insurance: ___________________________

Attorney Firm/Name: ____ Phone: ______________________________

We do require you to pay your co-payments and deductibles at the time of service. We accept cash, checks, Visa, Master Card and American Express. Please understand that any monies collected at the time of visit are only an estimated amount of your financial responsibility and do not represent the total financial responsibility due for the services rendered. In most cases, we will bill your insurance for you. Please understand that is a courtesy for our patients, not our responsibility. Your insurance contract is between you and your insurance company. It is YOUR responsibility to understand the terms and benefits, which are a part of your contract. If you are unsure what your benefits are, you should contact your benefits department for verification prior to your visit.

I have read the foregoing, have received a copy thereof (upon my request), and I am personally empowered, or am duly authorized by the patient, as patient's general agent to execute the above. It is my responsibility to consult with my insurance company regarding payment and authorizations required prior to my visit. I hereby assign Centers For Imaging LLC to submit claims to insurance companies plan administrators, and/or attorneys and to apply insurance proceeds to Centers For Imaging LLC. If refunds are due under the provision of such insurance policies. If your insurance company has not paid your bill in full within 60 days, you will be expected to pay in full the balance. Any balance due from you after your insurance has paid will be due within 30 days from receipt of your statement. In the event of a large balance due, we can arrange a payment plan suitable for all parties concerned.

Patient Signature: ____ Date: __________________________

Parent or Legal Guardian Signature: ____ Relationship: ________________

OFFICE USE ONLY

Today's Financial Responsibility $___________ Previous Balance: $_________ Other Amount: $___________

Total Due: $_________ Payment type: ___________ Payment Amount: $_________ Done by: _________________

CC Report to: ____________________________ Primary Insurance: _____________________ Secondary: _______________

Prior Studies: ____

Tech: ______________ Rad: ________________ CT/MR Contrast CPT Code: ____________ Unit # _________ ML

CPT Code	Internal Study Code	CPT Code	Internal Study Code
_____________	_________________	_______________	____________________
_____________	_________________	_______________	____________________
_____________	_________________	_______________	____________________

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Notice of Privacy Practices

Centers For Imaging, LLC, (CFI) is required by law to maintain the privacy of your protected health information. The Notice of Privacy Practices tells you how your protected health information may be used and how CFI keeps your information private and confidential. This notice explains the legal duties and practices relating to you protected health information. As a part of CFI's legal duties this Notice of Privacy Practices must be given to you upon your request. CFI is required to follow the terms of the Notice of Privacy Practices currently in effect. CFI may change the terms of its notice. The change, if made, will be effective for all protected health information that it maintains. New or revised notices of privacy practices will be posted on CFI Centers and will be available by email upon request.

Uses and Disclosures of your protected Health Information

Protected health information includes demographics and medical information that concerns the past, present, and/or future physical or mental health of an individual. Demographics information could include our name, address, phone number, social security number and any other means of identifying you as a specific person. Protected health information contains specific information that identifies a person or can be used to identify a person. Protected health information is health information created or received by a health care provider, health plan, employer, or health care clearinghouse. CFI can act as each of the above business type. This medical information is used by CFI in many ways while performing normal business activities. Your protected health information may be used or disclosed by CFI for purposes of treatment, payment and health care operations.

Healthcare professionals use medical information in the clinics or hospitals to take care of you. Your protected health information may be shared, with or without your consent, with another healthcare provider for purposes of your treatment. CFI may use or disclose your health information with case management and services. CFI may send the medical information to insurance companies, Medicaid, or community agencies to pay for the services provided to you. Your information may be used by certain department personnel to improve CFI 's healthcare operations. CFI also may send you appointment reminders, information about your treatment options or other health related benefits and services. Some protected health information can disclose without your written authorization as allowed b y law. Those circumstances include:

- Reporting abuse of children, adults, or disabled persons.
- Investigations related to a missing child.
- Interval investigations and audits by CFI's divisions, bureaus, offices.
- Investigations and audits by the state's Inspector General and Auditor General and the legislature's Office of Program Policy Analysis and Government Accountability.
- Public health purposes including vital statistics, disease reporting, public health surveillance, investigations, interventions, and regulations of health professionals.
- District medical examiner investigations.
- Research approved by CFI.
- Court orders, warrants, or subpoenas.
- Law enforcement purposes, administrative investigations, judicial and administrative proceedings.

Other uses and disclosures of your protected health information by CFI will require your written authorization. This authorization will have an expiration date that can be revoked by you in writing. These uses and disclosures may be for marketing and for research purposes. Certain uses and disclosure of psychotherapist notes will also require your written authorization.

Individual Rights

You have the right to request CFI to restrict the use and disclosure of your protected health information to carry out treatment, payment, or health care operations. You may also limit disclosures to individuals involved with your care. CFI is not required to agree to any restrictions. You have the right to be assure that your information will be kept confidential. CFI may mail or call you with health care appointment reminders. We will make contact with you in the manner and at the address or phone number you select. You may be asked to put your request in writing. If you are responsible to pay for services, you may provide an address other than your residence where you can receive mail and where we may contact you. You have the right to inspect and receive a copy of your protected health information. Your inspection of information will be supervised at an appointed time and place. You may be denied access as specified by law. If access is denied, you have the right to request a review by a licensed health care professional who was no involved in the decision to deny access. This licensed health care professional will be designated by CFI.

Individual Rights

You have the right to correct your protected health information. Your request to correct your protected health information must be in writing and provide a reason to support your requested correction. CFI may deny your request, in whole or part, if it finds the protected health information:

- Was not created by Centers For Imaging.
- Is not protected health information.
- Is by law not available for your inspection or
- Is accurate and complete.

If your correction is accepted, Centers For Imaging will make the correction and tell you and other who need to know about the correction. If your request is denied, you may send a letter detailing the reason you disagree with the decision. CFI will respond to your letter in writing. You also may file a complaint, as described below in the section titles Complaints. You have the right to receive a summary of certain disclosures CFI may have made of your protected health information. This summary does NOT include:

- Disclosures made to you.
- Disclosures to individuals involved with your care.
- Disclosures authorized by you.
- Disclosures made to carry out treatment, payment and healthcare operations.
- Disclosures for public health.
- Disclosures for health professional regulatory purposes.
- Disclosures to report abuse of children, adults or disabled.
- Disclosures prior to April 14, 2003.

This summary does include made for:

- Purposes of research, other than those you are authorized in writing.
- Responses to court orders, subpoenas, or warrants.
- You may request a summary for not more than a 6-year period from the date of your request.
- If you received the Notice of Privacy Practices electronically, you have the right to a paper copy upon request.

There is a written management agreement between Affinity Integrative Healthcare Center, LLC and Integrative Physical Medicine Holding, LLC which owns Centers For Imaging.

Complaints

If you believe your privacy has been violated, you may file a complaint with the:

Department of Health's Inspector General
4052 Bald Cypress Way BIN A03
Tallahassee, Florida 32399-1704
850-245-4141

Secretary of the U.S. Department of Health and Human Services
200 Independence Way S.W.
Washington D.C. 20201
202-619-0257 Toll Free 877-696-6775

The complaint must be in writing, describe the acts or omissions that you believe violate your privacy rights, and be filed within 180 days of when you knew or should have known the act or omission occurred. CFI will not retaliate against you for filing a complaint.

Further Information

Request for further information about the matters covered by this notice may be directed to the person who gave you the notice. The director or administrator of CFI facility where you received the notice, or to:
Department of Health, Inspector General
4052 Bald Cypress Way Bin A03
Tallahassee, Florida 32399-1704
850-245-4141

Effective Date

This Notice of Privacy Practices is effective beginning June 6, 2007 and shall be in effect until a new Notice of Privacy Practices is approved and Posted.

References

"Standards for the Privacy of Individually Identifiable Health Information; Final Rule 45 CFR Parts 160 – 164 Federal Register, Volume 65, No. 250 (December 28, 2000)"
"Standards for the Privacy of Individually Identifiable Health Information; Final Rule 45 CFR Parts 160 – 164 Federal Register, Volume 67, No. 250 (August 14, 2002)"

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HIPAA and Disclosure Authorization for Information Request

Patient Name: ______________________________ **DOB:** __________________________

I acknowledge that a copy of the Notice of Privacy Practices that outlines how patient confidential information will be used, disclosed, protected and how I can get access to this information, is available to me upon request.
Pursuant to the Health Insurance Portability and Accountability Act (HIPAA), I hereby authorize the following providers (List below all providers from whom information is being sought) to disclose the following protected health information to Centers For Imaging LLC.

____
____

Check as applicable

____ Copies of any diagnostic image tests taken within the past seven years
____ Medical history, including specific progress notes regarding any problems that would impact surgery or procedure's progress or outcome.
____ A list of Allergies
____ Result of relevant diagnostic or laboratory tests.
____ Other: ____

This protected health information is being used by the facility for the purpose of preparation for an outpatient procedure at Centers For Imaging LLC. This authorization shall be enforced and effective until: ___________________

I understand that, as set forth in the health care facility's Privacy Notice, I have the right to revoke this authorization, in writing at any time by sending written notification to:

1343 S. International Parkway
Lake Mary, FL 32746

106 W. North Blvd Suite 104
Leesburg, FL 34748

1205 E. Magnolia St. Suite 109
Lakeland, FL 33801

- I authorize Centers For Imaging to release films and/or reports regarding my radiographic exams to treating healthcare providers that will be providing medical treatment or service to me.
- I understand that a revocation is not effective to the extent that the healthcare facility has relied on the use or disclosure of the protected health information.
- I understand that information used and disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
- I understand that the health care facility will not condition my treatment on whether I provide authorization for the requested disclosure.

____
Name of Patient or Personal Representative

____
Description of Personal Representative's Authority

____
Signature of Patient or Personal Representative

____
Date

Fax Reports to: Centers For Imaging Centers ________________________ Attention: ______________________ ________

Patient will pick up on ____

Courier will pick up on ___________________________________ Courier Name: _______________________________