Patient Name:_____ Date of Birth:_____ Weight:_____ Height:_____

Florida Mailing Address:_____

****Add any other address in the Secondary address area****

City:_____ State:_____ Zip:_____ Sex: M F Marital Status: S M W D

Home Phone #:_____ Cell #:_____ SS#:_____

Primary Insurance (Company name):_____ Secondary (Company name):_____

Primary Policy Holder:_____ DOB:_____ SS#:_____

****************Guarantor Information or Secondary Address Information****************

Name:_____ DOB:_____ SS#:_____

Mailing Address:_____ City:_____ State:_____ Zip:_____

Phone:_____ Cell:_____ Relationship to patient:_____

FEDERAL GOVERMNENT MANDATED MEANINGFUL USE PATIENT INFORMATION

The below information is *optional*. If you decline to answer, *please mark the appropriate areas*, *sign*, and *date* below.

Ethnicity: ☐Declined ☐Hispanic or Latino ☐Not Hispanic or Latino

Race: ☐Declined ☐American Indian ☐Asian ☐Black or African American ☐Native Hawaiian or other Pacific Islander ☐White

Smoking Status: ☐Declined ☐Current every-day smoker ☐Current some-days smoker ☐Former smoker ☐Never smoked ☐Smoker, current status unknown ☐Unknown if ever smoked

Non-Disclosure of Patient Demographic Information: By signing and dating below, I hereby decline to provide my ethnicity, race, and smoking status to Inverness Medical Imaging (IMI). I understand that I maintain the right to disclose this information to IMI at any time and that, upon exercising disclosure, any newly provided information will be added to my patient record.

Patient/Parent/Legal Representative Signature: X_____ **Date:**_____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the *Health Insurance Portability & Accountability Act of 1996* (HIPAA), I have certain rights to privacy regarding my *Protected Health Information* (PHI). I understand that this information can and will be used to conduct, plan, and direct my treatment and follow-up among the healthcare providers who may be directly or indirectly involved in my treatment; to obtain payment from third-party payers; and to conduct normal healthcare operations such as quality assessments and physician certifications.

I received, read, and now understand Inverness Medical Imaging's (IMI's) *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my PHI. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of their *Notice of Privacy Practices*.

Patient/Parent/Legal Representative: _____ **Signature:** X_____ **Date:** _____

Practice use only

I attempted to obtain the patient's signature with acknowledgement of the *Notice of Privacy Practices* but was unable to do so as documented.				
Date:		Initials:		Reason:

Insurance: Your insurance policy is a contract between you and your insurance company. IMI cannot guarantee payment for any claim; it is the responsibility of the policy holder to know who accepts your policy. Please remember insurance is a method of reimbursing the patient for fees paid to the provider and not a substitute for payment. Insurance companies vary widely in their calculations and payments to the healthcare industry, therefore, IMI is not liable for any insurance reduction based on the policy or plan you have chosen. In the event that the carrier has provided IMI with incorrect information, the patient/guardian will be responsible for any services rendered.

All patient responsibility calculations are based on information your insurance company has supplied to IMI, therefore, any payments or payment options you have made may be adjusted to reflect what your insurance company has deemed payable or non-payable under your contracted policy.

No-Show/Cancelation Policy: A 24-hour advance notice of cancellation or rescheduling of an appointment must be given or a **$75.00 fee** will be imposed for any **CT** or **MRI** with an additional **$25.00 fee for each additional exam** that is scheduled on the same day. All other exams will impose a **$35.00** no-show fee if no advance notice is given.

Nuclear Medicine Exam Cancelation/No-Show: No-show fees are based on the price of the pharmaceutical that must be ordered in advance for your scheduled exam; this could range from **$16.00** up to **$1,300.00**. If a 24-hour advance notice of cancellation or rescheduling is not made, you will be responsible for the cost of the pharmaceuticals since we cannot return them. This is not a onetime fee. Fees will be assessed each time an appointment has not been cancelled within the adequate time frame.

I authorize Inverness Medical Imaging to disclose my PHI concerning my appointments, billing or financial information and medical information to the following individuals. IMI cannot release any of your PHI per HIPAA law unless you authorize their release. Any person trying to obtain access to your records without your below consent will result in a denial of release of records.

List the full FIRST and LAST names of the corresponding persons to be permitted access to your PHI (*optional*):

Spouse:_____ Parent(s):_____ Grandparent(s):_____

Legal Guardian(s):_____ Children:_____ Other(s):_____

IF the patient is under the age of 18, a parent or legal guardian must sign. A legal guardian must present proper legal paperwork.

Patient/Parent/Legal Representative Signature: X_____ **Date:**_____