RADIOLOGY ASSOCIATES OF TALLAHASSEE & TALLAHASSEE DIAGNOSTIC IMAGING

Today's Date _____ MPI # _____

SSN _____ DOB _____ Sex _____ Referred by Dr. _____

Last Name _____ First Name _____ Middle Name _____ Suffix _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work _____ Cell _____

NOTE: If your visit is related to an accident, you must provide complete insurance information including the claim # before being treated in this office. Florida Statutes state that claims must be filed within **35** days after receiving treatment. If you fail to notify us that this is an auto accident related claim or a worker's comp claim, you could be liable for payment of the bill.

Is this visit related to an accident or injury at work? **Date of Accident** _____

Auto ___**Yes** ___**No** **Worker's Comp** ___**Yes** ___**No** **Other** ___**Yes** ___**No**

If "Other", type of Accident _____

INSURANCE INFORMATION

Primary Insurance _____ Group # / Name _____

Address _____ City _____

State _____ Zip _____ Phone # _____ Policy / Claim # _____

Name of Insured _____ Relationship _____ SSN _____

DOB of Insured _____ Address _____

City _____ State _____ Zip _____ Phone _____

Secondary Insurance _____ Group # / Name _____

Address _____ City _____

State _____ Zip _____ Phone # _____ Policy / Claim # _____

Name of Insured _____ Relationship _____ SSN _____

DOB of Insured _____ Address _____

City _____ State _____ Zip _____ Phone _____

EMPLOYER INFORMATION (Must be completed if a work-related injury)

Patient's Employer (or Insured's Employer if patient is a minor) _____

Address _____ City _____ State _____ Zip _____ Phone _____

GUARANTOR (IF OTHER THAN PATIENT)

Last Name _____ First Name _____ Middle Name _____ Suffix _____

SSN _____ DOB _____ Sex _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work _____ Cell _____

EMERGENCY CONTACT INFORMATION

In case of emergency, I authorize
this facility to contact: Name _____ Relationship _____

Home Phone _____ Work _____ Cell _____

SIGNATURE

I authorize the release of medical information necessary to process this claim. I authorize payment of medical benefits to the undersigned physician or supplier for services rendered. I understand I am financially responsible for services rendered by Radiology Associates of Tallahassee or Tallahassee Diagnostic Imaging.

Patient or Guarantor Signature _____ DATE _____

Printed Name (if other than patient) _____

Radiology Associates of Tallahassee
Tallahassee Diagnostic Imaging
1600 Phillips Road • Tallahassee, FL 32308
850-878-4127

CONSENT FOR THE USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give consent to Radiology Associates of Tallahassee, P.A. / Tallahassee Diagnostic Imaging and all health care providers furnishing care within the practice to use and disclose my protected health information for the purposes of treatment and health care operations.

My "protected health care information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

Please be advised that our Notice of Privacy Practices provides more detailed information about how we may use and disclose your protected health information. You have the right to review our Notice of Privacy Practices before you sign this consent.

We reserve the right to change the terms of our Notice of Privacy Practices. You may obtain a copy of the current notice by asking for a copy when you check in at the front desk or by contacting our Privacy Officer at 850-878-4127.

You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required to grant your request but if we do, the restrictions will be binding on us.

You may revoke this consent at any time. Your revocation must be in writing, signed by you or on your behalf, and delivered to the above address. You may deliver your revocation by any means you choose but it will be effective only when we actually receive the revocation. Your revocation will not be effective to the extent that we or others have acted in reliance upon this consent.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Have you received a copy of our Notice of Privacy Practices? _____Yes _____No

Would you like to review our policy? _____Yes _____No

Signed:_____ Date:_____

Print Name of Patient:_____

If you are signing as the patient's
representative, print your name:_____

Describe your authority:_____