Summit Imaging
12037 Cortez Boulevard
Brooksville, Florida 34613
(352) 597-9008 • Fax: (352) 597-1008

PATIENT REGISTRATION FORM

Patient's Name: Last: _____ First: _____ Middle: _____

Social Security #: _____ Male ❑ or Female ❑ Date of Birth: _____

Address: _____ City/State/Zip: _____

Phone: _____ Cell: _____ Work: _____

Retired: Yes ❑ or No ❑ Employer: _____ Phone: _____

Doctor Requesting Exam: _____ Other Doctor to Receive Report: _____

Primary Insurancy Company: _____ Phone: _____

Policyholder's Name: _____ Date of Birth: _____

Relationship: _____ Social Security #: _____

Secondary Insurance Compay: _____ Phone: _____

Policyholder's Name: _____ Date of Birth: _____

Relationship: _____ Social Security #: _____

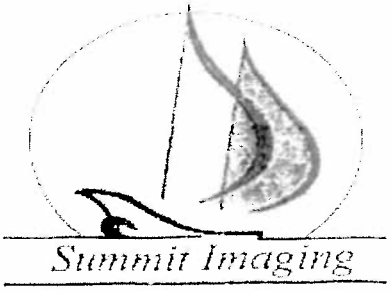
Acknowledgement and Assignment of Benefits: I hereby acknowledge that I have received medical services from Summit Imaging. In consideration of the services and treatment rendered, I hereby authorize and direct payment of medical benefits to Summit Imaging and assign and all causes of action that I may have against any insurance company (including all coverages for PIP and/or Med-pay, as a result of a vehicular accident), obligated to me by law, statute, or contractual agreement, for payment for such medical services and treatment. I direct my insurer to escrow any personal injury protection and / medical payments benefits it disputed for services or treatments rendered to me by Summit Imaging. I also understand that the medical services rendered by Summit Imaging could have been obtained by other providers but chose to obtain said services and treatment from said facility. I also authorize the release of any pertinent information or medical records to Summit Imaging and any other medical provider, insurance company or attorney involved with my medical treatment or case and/or litigation, that is seeking to obtain payment for medical services and treatment rendered by Summit Imaging, and others on its behalf. I hereby direct my insurance carrier to provide a copy of the PIP log or benefit payout sheet as well as any written explanation as to payments or reductions made or denied or other correspondence pertaining to a claim for services or treatment rendered to me as specified herein. A photocopy of this assignment shall be considered as valid and effective as the original.

I hereby acknowledge that Summit Imaging and employees do not assume responsibility for securing valuables or personal items belonging to patients or visitors. Although lockers may be available, they are intended only as a convenience and should not be considered secure.

I have read the above statement and understand that I am fully responsible for securing my valuable or personal items. I further acknoweldge that this facility and its employees are not liable for the loss or theft of these items.

I agree that the information supplied on this form are accurate and up to date to the best of my knowledge.

Signature of Patient or Representative: _____ **Date:** _____



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HIPAA RELEASE FORM

Patient Name:_____ Date of Birth: ____/____/_____

Release of Medical Information

__ I hereby authorize the release of my information including the diagnosis, and any records of all examinations rendered to me. This includes any of my insurance claim information.

This information may be released to:

__ Spouse (Name)_____

__ Child(ren) (Name) _____

__ Parents (Name) _____

__ Information is NOT to be released to anyone.

** *release of information* will remain in effect until terminated by me in writing.

Your records will automatically be sent to your ordering doctor.

****This form applies to your personal records only.****

Patient Signature: _____ Date: ____/____/_____

Witness: _____ Date: ____/____/_____

SUMMIT IMAGING

Patient Consent Form

(Please Read and Sign)

My physician has referred me for a(n) _____. I understand that the practice of medicine is not an exact science and no guarantee can be made as to the results that might be obtained from this procedure.

I understand complications can occur. By consenting to this exam, I hereby consent to the necessary medical or surgical actions of the physician and/or colleagues, medical/surgical; whomever they choose to consult with to take appropriate actions in regard to this procedure should any complications occur during my visit.

I understand that Summit Imaging may include consent at satellite offices under common ownership.

Patient Initial: _____

I, the undersigned, authorize Summit Imaging to use and disclose my information for the purposes of treatment, payment, and healthcare operations as described in the Notice of Privacy Practices.

Patient Financial Responsibility: I understand my financial responsibility and I guarantee payment for all charges not covered by my insurance, all applied deductibles and co-pays, within 30 days of receiving a statement. MEDICARE PATIENTS: I authorize to release medical information about me to the Centers for Medicare & Medicaid Services (CMS) or its intermediaries for my Medicare claims. I assign the benefits payable for services to Summit Imaging.

I acknowledge that I have been given the Summit Imaging Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact the Privacy Official.

Patient Initial: _____

In the last seven (7) days, please indicate if you have had:

❑ Yes ❑ No Fever greater than 100 F

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____ _____

Patient (or person authorized to consent for the patient) Relationship

_____ _____

Witness Date/Time

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CONSENT FOR MINORS

Date: _____

Patient's Name: _____ Age: _____

I (We) hereby request and authorize this imaging facility to perform the following diagnostic procedure _____

It is understood that this examination has been requested by the minor's physician, who has fully to my knowledge and consent explained any potential risks involved. In order to assist the physician in the diagnosis and care of the ailment, I, the parent/guardian of the minor named above, give consent to the procedure.

The foregoing consent was read, discussed, and signed in my presence and in my opinion the person(s) signing did so freely and with full knowledge and understanding.

_____ Date: _____
Parent/Guardian Signature

_____
Relationship to Minor

The foregoing consent was read, discussed, and signed in my presence and in my opinion the person(s) signing did so freely and with full knowledge and understanding.

_____ Date: _____
Witness Signature

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BONE MINERAL DENSITOMETRY QUESTIONNAIRE

Patient Name: _____ Date: _____

Birthdate: _____ Ethnic Group: _____ Male / Female

Height: _____ Weight: _____ Referring Physician: _____

Have you:	Had a recent Nuclear Medicine or barium study?	YES	NO
	Taken a calcium supplement in the last 24 hours?	YES	NO
	Had a previous bone density study (DEXA)?	YES	NO

Check any of the following that apply to you:

_____ Surgery on back

_____ Surgery on hip R L

_____ Paget's disease

_____ Thyroid disease

_____ Parathyroid disease

_____ Family history osteoporosis

_____ Cancer (type and date) _____

_____ Broken bone as an adult (site and date) _____

Check any of the following medication that you take or have taken:

_____ Steroids - (i.e. Prednisone)

_____ Hormones - (i.e. Estrogen - Progesterone)

_____ Thyroid - (i.e. Synthroid - Levothyroxine)

_____ Osteoporosis medication - (i.e. Fosamax - Actonel - Boniva)

For Women Only

Have you:	Had a hysterectomy?	YES	NO	AGE_____
	Had your ovaries removed?	YES	NO	AGE_____
	Gone through menopause?	YES	NO	AGE_____

PET/CT FDG Scan Questionnaire Form

Patient Name: _____ Today's Date: _____

Reason for PET/CT scan? _____

Height: _____ Weight: _____

☐ YES ☐ NO **Are you diabetic?** (Type) _____
☐ YES ☐ NO **Do you take insulin?**
☐ YES ☐ NO **Do you take oral diabetic medications?**
☐ YES ☐ NO **Do you take Neupogen, Leukine or Neulasta after chemo?**

_____
_____

Do you have a **history of tumors of cancer** in your body? If yes, please list them with year of diagnosis:

_____

List any surgeries or biopsies with dates in the past 6 months and any surgery with date related to your cancer: _____

☐ YES ☐ NO **Have you had radiation therapy?** When was your last radiation therapy? _____

_____

What part of your body received radiation therapy? _____

☐ YES ☐ NO **Have you had chemotherapy?** When was your last chemotherapy? _____

When was your most recent **PET Scan?** _____ ☐ No recent PET

When was your most recent **CT Scan?** _____ ☐ No recent CT
What part of your body? _____

When was your most recent **MRI Scan?** _____ ☐ No recent MRI
What part of your body? _____

FEMALE PATIENTS:
☐ YES ☐ NO **Is there any possibility you could be pregnant?** LMP? _____
☐ YES ☐ NO **Are you breastfeeding?** (Follow special instructions given at scheduling.)

TECHNOLOGIST INJECTION INFORMATION

Questionnaire must be reviewed with patient. *Technologist Initials:* _____
(Make sure the questionnaire has been completed, and it matches Intake Form and Body Sheet)

IV Site: _____ Initial Assay: _____ mCi Assay Time: _____

Glucose Level: _____ Post Assay: _____ mCi: Injection Time: _____

Injected: _____ mCi Scan Start Time : _____

Time between Injection and Start of Exam _____ min CTDI _____ DLP _____

_____ No Contrast ☐ 2D ☐ 3D

_____ 16 oz Oral Water *By (Technologist):* _____

A. Notifier: SUMMIT IMAGING

B. Patient Name: C. Identification Number:

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.** EXAM listed below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the D. EXAM below.

D.	E. Reason Medicare May Not Pay:		F. Estimated Cost
SCREENING MAMMOGRAM	___ Medicare does not pay for the item(s) or service(s) for your condition. _x_ Medicare does not pay for the item(s) or service(s) more often that 1 time per year Medicare does not pay for experimental or research use items or services. __Other: __May not be considered medically necessary_____.		$195.84

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** exam listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

x **OPTION 1.** I want the **D. EXAM** listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.** _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the **D.** _____ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048).
Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

PT NAME:_____

COMMERCIAL ADVANCE BENEFICIARY NOTICE OF NON-COVERAGE (COMMERCIAL ABN)

NOTE: If Insurance doesn't pay for the procedure listed below, you may have to pay.

Your private insurance carrier does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect your insurance carrier may not pay for the procedure listed below.

Procedure	Reason Insurance May Not Pay:	Estimated Cost:
DIGITAL SCREENING MAMMOGRAM	Insurance will cover this exam 1 time per year.	$141.74

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the procedure listed above.

OPTIONS: **Check only one box. We cannot choose a box for you.**

X OPTION 1. I want the _exam_ listed above. **You will not be asked for payment at time of service**. I want Insurance billed for an official decision on payment, which is sent to me on an Explanation of Benefits (EOB). I understand that if Insurance doesn't pay, I am responsible for payment in full. If you appeal to your Insurance Carrier and they do pay, you will be refunded any payments made to this facility, less co-pays or deductibles.

❑ OPTION 2. I want the _____ listed above, but do not bill Insurance. **You will be asked for payment at time of service**. I am responsible for payment. I cannot appeal if a claim is not is not billed.

❑ OPTION 3. I don't want the _____ listed above. I understand with this choice **I am not responsible for payment**, and I cannot appeal to see if my Insurance Carrier would pay.

Additional Information:

This notice gives our opinion, not an official decision. If you have other questions on coverage please call your Insurance Carrier.

Signing below means that you have received and understand this notice. You also receive a copy.

Signature:	Date:

PT NAME: _____

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NOTE: If Insurance doesn't pay for the procedure listed below, you may have to pay.

Your private insurance carrier does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect your insurance carrier may not pay for the procedure listed below.

Procedure	Reason Insurance May Not Pay:	Estimated Cost:
DEXA SCAN	Insurance will only cover if found to be Medically Necessary and has not been performed in the past 2 years	$97.60

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
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OPTIONS: Check only one box. We cannot choose a box for you.

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Signature: _____ Date: _____

A. Notifier: SUMMIT IMAGING

B. Patient Name: C. Identification Number:

Advance Beneficiary Notice of Noncoverage (ABN)

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D.	E. Reason Medicare May Not Pay:		F. Estimated Cost
DEXA SCAN	___ Medicare does not pay for the item(s) or service(s) for your condition. __Medicare does not pay for the item(s) or service(s) more often that 1 time per year Medicare does not pay for experimental or research use items or services. _x_Other: __May not be considered medically necessary		$97.60

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