Tower Radiology Centers

Account # _____

PSR Initials _____

Patient Data Sheet

Patient Name *Last* _____ *First* _____

Name of Parent *(If patient is Minor)* _____

Patient Address _____ **Apt/Suite #** _____

City _____ **State** _____ **Zip** _____

Birthdate _____/_____/_____ **Age** _____ **Gender** **M** _____ **F** _____

Home Phone _____ **Work Phone** _____ **Cell Phone** _____

SSN _____ - _____ - _____ **Email Address** _____

Referring Doctor _____ **Address** _____

Additional Physicians to Send Report _____ **Address** _____

Are you pregnant? **No** _____ **Yes** _____ **Unsure** _____ **Marital Status** _____

Name of Policy Holder _____ **Policy Holder DOB:** _____

Name of Employer _____ **Work Phone** _____

Relationship to Policy Holder: O Self O Spouse O Dependent Child O Student O Other

Primary Insurance Name _____

Second Insurance Name _____ **Third Insurance Name** _____

Please complete the following applicable fields:

Is Injury due to an Accident: **Yes** O **No** O **Date of Injury:** _____ **Insurance Claim #:** _____

If Yes, what type? **Auto** O **Work Comp.** O **Motorcycle** O **Pedestrian Struck By Car** O **Slip & Fall** O **Other Accident** O

Auto Insurance Name _____ **Claims Adjuster** _____ **Phone #** _____

Attorney/Firm Name _____ **Attorney Phone #** _____

I CONFIRM THAT ALL OF THE ABOVE INFORMATION IS TRUE AND CORRECT

_____ _____

Signature of Patient or Personal Representative **Date**

OVER

CONSENT FOR TREATMENT

I authorize Tower Imaging, LLC. (TOWER) to furnish the necessary medical treatment or procedure(s); including diagnostic and/or laboratory procedures, and drugs and supplies as may be ordered by the referring physician(s), their assistants, or their designees. I am aware the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of these diagnostic procedures or treatment. I recognize the physicians who practice at TOWER may not be employees or agents of TOWER but may be independent physicians. TOWER may delegate to these independent physicians those services provided and any questions related to care the independent physician has given or ordered should be directed to him/her.

Signature of Patient or Personal Representative **Date**

AUTHORIZATION

This authorization extends to all of my protected health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) that is disclosed for general information purposes and is valid until revoked. I authorize Tower Imaging, Inc., (TOWER) the right to obtain all medical information necessary to process my diagnostic test(s); the assignment of benefits from any applicable government funded health program related to this claim; and the right to request payment and to obtain or release any medical information necessary for payment under applicable government funded health programs, managed care plans and/or private insurance. I authorize any holder of medical or other information about me to release such information needed to process this claim or related claims. I understand that I may revoke this authorization in writing, at any time, except where information has already been released by sending it to Attention: Privacy Officer, Tower Imaging, Inc., 2700 University Square Drive, Tampa, FL 33612. TOWER, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. I understand that I can request that TOWER restrict disclosure to my health plan or its business associate only if I have paid out-of-pocket in full for the services provided.

I understand the fact that I may have insurance does not release me of my personal responsibility for payment. If I do not provide complete and correct insurance information at the time of service, it may not be possible to bill insurance at a later date and I will be responsible for payment. I understand I must pay for non-covered services, services deemed non-reimbursable by my insurance company, co- insurance and deductibles due for medical services. I also agree to pay any reasonable collection costs for any overdue balance. You are entitled to a copy of this authorization after you sign it.

Signature of Patient or Personal Representative **Date**

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have been provided a copy of the Notice of Privacy Practices for Tower Imaging, LLC., (TOWER). I hereby authorize, as indicated by my signature below, TOWER to use and to disclose my protected health information for any necessary clinical, financial, and insurance purpose, as also authorized in the Registration and Consent forms.

I authorize TOWER to speak to the following persons about my Protected Health Information (PHI), billing and/or test results:

1. _____ DOB _____ Date Added / Removed: _____

2. _____ DOB _____ Date Added / Removed: _____

In case of emergency, please contact: _____

Relationship to Patient: _____ Contact Number: _____

Signature of Patient or Personal Representative **Date**

A NOTE TO OUR VALUED PATIENTS:

Most of the diagnostic radiology services at Tower Radiology Centers are provided by physicians from Radiology Associates of Florida. On occasion, some diagnostic radiology services may be provided by physicians employed by our academic partner, the University of South Florida, necessitating the special notice provided below.

I acknowledge that I have been given this separate written conspicuous notice by the University of South Florida/University of South Florida Board of Trustees, a public body corporate of the State of Florida ("USF") and Radiology Associates of Florida, P.A and Tower Imaging that some or all of the radiology services, care and treatment I receive will or may be provided by physicians who are employees and/or agents of USF, and liability, if any, that may arise from that care is limited as provided by law. I hereby certify that I am the patient or a person who is authorized to give consent for the patient.

_____ _____

Signature of Patient or Personal Representative **Date**

PERSONAL ITEMS

I am responsible for my own personal belongings. Lockers and/or patient belonging bags are available to secure your personal items.

_____ _____

Signature of Patient or Personal Representative **Date**

FOR PATIENTS HAVING MRI EXAMS

If you are having an MRI with contrast, you will be given a gadolinium based contrast agent (GBCA) through your IV. GBCAs may make it easier to diagnose certain health conditions earlier and/or more accurately. GBCAs were first developed and approved for human diagnostic use in 1988 in the United States and have been in clinical use for 30 years. Hundreds of millions of doses have been given to patients throughout the world.

A tiny amount of the gadolinium within the GBCA has been found to stay in several parts of the body for months or years. The possible long-term effects of this have not yet been determined, but to date **no** studies have found any harmful effects from this retention. At Tower Radiology, we utilize the safest contrast agents with the most clinical benefit. A specially trained MRI technologist will review your medical history and important records in consultation with a board certified radiologist, if needed, and determine if your MRI study needs one of these agents. If you would like more information to take home on the contrast we use, please ask a Tower employee.

Thank you for trusting your care to us. Your health is our primary concern.