PATIENT DATA SHEET

Account # _____

PSR Initials _____

Patient Name *Last* _____ *First* _____

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

Patient Address _____

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

Birthdate ____/____/____ **Age** _____ **Gender M** _____ **F** _____ **SSN** _____-_____-_____

Home Phone _____ **Work Phone** _____ **Cell Phone** _____ **Email Address** _____

Referring Doctor _____ **Address** _____

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

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

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** _____

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**

CONSENT FOR TREATMENT

I authorize Tower Imaging, Inc., Community Diagnostic Center, Maru Diagnostic Imaging and Tower OpenScan MRI (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 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., Community Diagnostic Center, Maru Diagnostic Imaging and Tower OpenScan MRI (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 having 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, coinsurance and deductibles due for medical services. I also agree to pay any reasonable collection costs for any overuse 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, Inc., Community Diagnostic Center, Maru Diagnostic Imaging and Tower OpenScan MRI (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._____ Date Added / Removed: _____

2._____ Date Added / Removed: _____

In case of emergency, please contact: _____

Relationship to Patient: _____ Contact Number: _____

_____ _____

Signature of Patient or Personal Representative **Date**