ADVANCED IMAGING CONCEPTS
"Advancing the care you deserve."
NAVEEN BIKKASANI, MD ALKA KUMAR, MD CHARLES ANTHONY, MD

CASE TYPE /ATTORNEY INFO

1) What is the purpose of your visit today? (Circle the option that applies)
   - Auto Accident
   - Slip and Fall
   - Workers Compensation
   - Routine Visit
   - Other:_____

2) If you chose Auto or Slip and Fall, please inform us of the attorney that is representing you

_____

3) If you do not have an attorney, would you like more information on how to set up a free consultation with an attorney?
   - Yes
   - No
   - N/A

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STANDARD DISCLOSURE AND ACKNOWLEDGEMENT FORM
PERSONAL INJUREY PROTECTION – INITIAL TREATMENT OR SERVICE PROVIDED

The undersigned insured person (or guardian of such person) affirms:

1. The service or treatment set forth below was actually rendered. This means that those services have already been provided.

_____
_____
_____

2. I have the right and the duty to confirm that the services have already been provided.
3. I was not solicited by any person to seek any services from the medial provider of the services descript above.
4. The medical provider has explained the services to me for which payment is being claimed.

Insured Person (patient receiving treatment of services) or Guardian of Insured Person:

_____

Patient's Name (PRINT) Patients Signature Date

The undersigned licensed medical professional or medical director, if applicable, affirms the statement numbered 1 above also.

A. I have not solicited or caused the insured person, who was involved in a motor vehicle accident, to be so to make a claim for Personal Injury Protection benefits.
B. The treatment or services rendered were explained to the insured person, or his or her guardian, sufficient for that person to sign this form with informed consent.
C. The accompanying statement or bill is properly completed in all material provisions and all relevant inform has been provided therein. This means that each request for information has been responded to truthful accurately, and in a substantially complete manner.
D. The coding of procedures on the accompanying statement or bill is proper. This means that no service has been up coded, unbundled or constitutes an invalid or not medically necessary diagnostic test as defer Section 627.732 (15) and 16, Florida Statutes or Section 627.736 (5)(b) 6, Florida Statues.

Licensed Medical Professional Rendering Treatment/ Services or Medical Director, if applicable (Signature by his or her own hand):

Physician Name (PRINT) Physician Signature Date

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files, statement of claim or any application containing any false, incomplete, or misleading information is guilty of a felony or the third degree per section 817.234(1)(b). Florida
Note: The Original of this must be furnished to the insurer pursuant to Section 627.736(4)(b), Florida Statutes and may not be electronically furnished. Failure to furnish this form may result in non-payment of this claim.

Address: 13470 Taft Street Brooksville, FL 34613 *Phone: 352-597-0016* *Fax: 352-597-0089*

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LIFETIME AUTHORIZATION

INSURANCE ASSIGNMENTS AND AUTHORIZATION TO RELEASE INFORMATION

I. **RELEASE OF INFORMATION**: I below named patient, do hereby authorize any physician examining and/or treating me to release any third payor (such as an insurance company or government agency, example: Blue Shield of Florida or Medicare) any medical records concerning diagnosis and treatment when requested by such third party for its use in connection with determining a claim for payment.

II. **PHYSICIAN INSURANCE ASSIGNMENT**: I, the below named patient or legal representative of patient , hereby authorize payment directly to Advanced Imaging Concepts, P.L. or any physician treating me in the group and/or medical benefits herein specified and otherwise payable to me for their services as described but not to exceed the reasonable and customary charges for these services.

III. **MEDICARE/MEDICAID**: Patient's certification authorization to release information and payment requests. I certify that the information given by me is applying for payment under Title XVIII/XIX of the Social Security Administration/Division of Family Services or its Intermediaries or carries any information needed for this of a related Medicare/Medicaid (CMS) claim. I hereby certify all insurances pertaining to treatment shall be assigned to the physician treating me.

IV. **I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE WHICH IS NOT A PROVIDER CONTRACTABLE WRITE OFF**. I understand that Advanced Imaging Concepts (AIC) will make every effort to verify my insurance benefits and determine patient responsible amount prior to services rendered. This is not a guarantee of payment or benefits which will not be fully decided until the insurance plan processes the claim. In the event that there is a difference in the amount collected from the patient from what is patient responsibility determined by your insurance plan then the patient may be billed or refunded the difference.

V. **Under our Courtesy Billing Program,** we have asked your insurance company to pay us directly; however, some insurance companies may pay the patient instead. If this occurs, you are responsible to remit this amount to Advanced Imaging Concepts. We recommend that you submit a copy of the explanation of payment that comes with the check so we can determine any discounts that are to be made on the charges.

VI. **NOTIFY US IMMEDIATELY OF ANY CHANGES IN YOUR INSURANCE OR CHANGES IN YOUR ADDRESS AND TELEPHONE NUMBER**: Failure to notify us of changes or failure to notify us of all insurance coverages that are in effect could result in unnecessary patient responsibility of charges. It is extremely important to notify us if the services you are having are related to an accident or injury. We will need the date of this injury and the insurance that may be responsible for coverage. Failure to do so could result in denial of payment from your medical insurance carrier.

PATIENT SIGNATURE_____ DATE: _____

PRINTED PATIENT NAME: _____

LEGAL GUARDIAN OR RESPONSIBLE PARTY SIGNATURE (IF APPLICABLE)

SIGNATURE: _____ DATE: _____

RELATIONSHIP TO PATIENT: _____

PLEASE SEE OTHER SIDE >>>

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Dear Patient:

Advanced Imaging Concepts may use your protected health information for purposes of providing treatment, obtaining payment for treatment and conducting healthcare operations. You may receive a copy of our Notice of Privacy Practices for Protected Health Information, upon request as described in the Health Insurance Portability and Accountability Act of 1996, commonly known as HIPAA. This policy safeguards your personal health information. To comply with this law and to protect you we want you to know how we handle specific situations; so, we have summarized our policy below on some key situations:

PATIENT CONTACT:

1. We may send you a reminder letter through the mail when you are due for a routine appointment, such as but not limited to, a yearly reminder to schedule a mammogram.
2. We may call your home to remind you of a scheduled appointment. If you are unavailable or we reach your answering machine we may leave a message stating your name, and that you are scheduled for an appointment on a specific day, date and time. We may also leave instructions for a test preparation and any co payment that may be due at the time of the service. We will not state the name of the test that you are scheduled for.

If you *do not* want us to contact you in this manner please state what your wishes are we will do everything we can to honor them:

_____

_____

_____

_____

_____

MEDICAL RECORDS RELEASE:

1. **It is our policy to release medical records such as films and reports to any healthcare provider or family member, if requested, with proof of identification such as drivers license. I authorize the release of my medical records and/or x-ray film to AIC or from any healthcare entity as necessary for continued healthcare and comparison.** If there is a specific healthcare provider or family member you do not want us to release medical records to or you want us to handle your release in a specific way other then our normal policy than please tell us below:

   _____

   _____

   _____

Please sign this form, which will be added as part of your medical record confirming that you are aware of our Notice of Privacy Practices and that you have read this acknowledgment form and agree with our policy or have made changes in the spaces provided.

PATIENT'S SIGNATURE: _____**DATE**: _____

PRINTED NAME: _____

PLEASE SEE OTHER SIDE >>>

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MRI PATIENT FORM

Name: _____Weight: _____Date of Exam: _____

HISTORY OF CANCER? YES / NO_____ REASON FOR EXAM (SYMPTOMS): _____

PLEASE LIST PRIOR X-RAYS, CT SCANS, MRI'S, ULTRASOUNDS AND NUCLEAR MEDICINE TESTS YOU HAVE HAD:

TEST PERFORMED DATE FACILITY

_____

_____

LIST PRIOR SURGERIES: _____

DO YOU HAVE HISTORY OF **KIDNEY DISEASE INCLUDING RENAL FAILURE**, OR ARE YOU ON **DIALYSIS**: _____YES _____ NO

Do any of the following apply? YES / NO

_____Aneurysm clip

_____Metal fragment in head, eye past 6 wks

_____Metal spinal rods

_____Neurostimilator (TENS unit)

_____Penile prosthesis

_____Cardiac pacemaker/Cardiac defibrillator

_____Retinal tack in eye

_____Cochlear implant

_____Permanent Eye Makeup

_____Hearing aid/dentures

_____Claustrophobia

_____ Pregnancy

_____Intravascular coils, filters or stents within past 6 weeks

_____Fractures treated with pins screws, nails in Spine or skin (metal worker)

_____Insulin or Morphine pump Or Bone growth stimulator

List ALL medication allergies:_____

List Sedative medication & dose taken for this exam_____

CONSENTS FOR MRI EXAM & CONTRAST

I certify the above information of this form to be correct to the best of my knowledge. I understand that despite precautions, there is a limited risk of complications with this procedure. These complications could include possible injury if questions are incorrectly answered on the form. I give consent for this MRI scan to be performed.

Patient /Guardian Signature: _____ Date: _____

Your Doctor or the Radiologist has, or may, request the use of Gadolinium. Gadolinium is a MRI contrast agent that is given intravenously and may add useful information to your MRI examination. There is a small but significant possibility of an allergic reaction, which, in rare cases, could be fatal. I grant my permission for use of Gadolinium contrast.

Patient /Guardian Signature: _____ Date: _____

Technologist Signature: _____ Date: _____

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LETTER OF PROTECTION

Subject: IRREVOCABLE DOCTOR/FACILITY LIEN

TO WHOM IT MAY CONCERN:

I do hereby authorize **Advanced Imaging Concepts, PL** or its assigns, to furnish you upon request, my attorney, with a full report of the results of the MRI or other diagnostic services performed on me in regard to the accident in which I was involved.

Further, I hereby authorize and direct you, my attorney, to pay directly to Advanced Imaging concepts, PL any sums as may be due and owing for medical services rendered me both by reason of this accident and by reason of any other bill due this office and to withhold such sums from any settlement, judgement or verdict as may be necessary to adequately protect **Advanced Imaging Concepts, PL.** I hereby further give a priority lien on my case to **Advanced Imaging Concepts, PL** or its assigns against any and all proceeds of any settlement, judgement or verdict which may be paid to you, my attorney, or myself as a result of the injuries for which I have been treated or injuries in connection therewith.

I understand that I am directly and fully responsible to **Advanced Imaging Concepts, PL** for all my medical bills submitted by their office for services rendered and that in consideration of their waiting payment. I further understand that such payment is not contingent on any settlement, judgement or verdict by which I may eventually recover said fee.

Patient's Signature Date Patient's Name (Please Print)

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MANAGED CARE WAIVER - ADVANCED PATIENT NOTICE OF NON COVERAGE

Insurance companies and managed care plans do not pay for every test. In some cases your healthcare provider may have reason to believe that you need this test. We expect that your insurance may not pay for the test for one of the following reasons:

____ Authorization is not received before the procedure is rendered.

____ Authorization was denied by your insurance carrier.

____ Insurance is not showing eligibility for the date of service.

____ Diagnosis may not be considered medically necessary for the procedure performed.

____ Procedure may exceed the frequency standards for this test. For example most insurance plans will only pay for a Screening Mammogram once every 12 months. Bone Density test once every 2 years (unless on osteoporosis drug therapy or steroids) and Carotid Doppler every few years, 1 a year or every 6 months depending on the amount of stenosis or surgical date.

____ Other reason(s) not listed above:_____

LIST PROCEDURE(S) OF REASON CHECKED ABOVE:

_____

_____

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

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

❑ **OPTION 2.** I want the procedure(s) listed above, but do not bill my insurance. You may be asked to be paid now, as I am responsible for payment. **I cannot appeal if my insurance is not billed**.

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

This notice gives our opinion, not an official insurance plan decision. If you have other questions on this notice or insurance billing, call the customer service number on your insurance card. Signing below means that you have received and understand this notice. You also received a copy.

INSURANCE PLAN NAME: _____

PRINT PATIENT NAME: _____

Signature:	**Date:**

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A. Notifier:

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.**_____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.**_____below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

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.**_____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.

☐ **OPTION 1.** I want the **D.**_____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:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

Form CMS-R-131 (Exp. 03/2020) Form Approved OMB No. 0938-0566