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*

ADVANCED IMAGING CONCEPTS, PL.

Date: _____ **MRI PATIENT FORM**

Name _____ Age _____ Weight _____

Date of Birth _____/_____/_____ Male / Female

1.Reason for MRI and/or Symptoms:_____

2.History of Cancer: No /yes

If yes, please describe: _____

3. Have you had prior surgery or an operation (e.g., arthroscopy, endoscopy, etc.) of any kind?
No / Yes
If yes, please indicate the date and type of surgery:

Type of surgery _____

_____

4. Have you experienced any problem related to a previous MRI examination or MR procedure?
No / Yes

If yes, please describe: _____

5. Have you ever been injured by a metallic object or foreign body (e.g., BB, bullet, shrapnel, etc.)?
No / Yes

If yes, please describe: _____

6. Are you allergic to any medication? No / Yes

If yes, please list: _____

7. Do you have a history of asthma, allergic reaction, respiratory disease, or reaction to a contrast medium or dye used for an MRI, CT, or X-ray examination? No / Yes

If yes, please describe: _____

8. Do you have anemia or any disease(s) that affects your blood, a history of renal (kidney) disease, or seizures? No / Yes

If yes, please describe: _____

9. **For female patients:** Are you Pregnant or Breast Feeding No / Yes

FOR OFFICE USE ONLY:

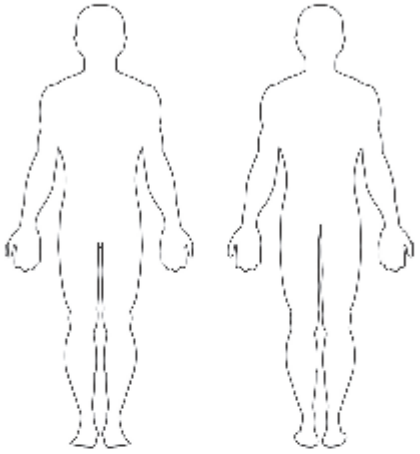
Contrast Used: _____ Injection Site: _____ Adverse Reaction: No/ Yes

WARNING: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure (i.e., MRI, MR angiography, functional MRI, MR spectroscopy). **Do not enter the MR system room or MR environment if you have any question or concern regarding an implant, device, or object. Consult the MRI Technologist or Radiologist BEFORE entering the MR system room. The MR system magnet is ALWAYS on.**

Please indicate if you have any of the following:

- ❑ Yes ❑ No Aneurysm clip(s)
- ❑ Yes ❑ No Cardiac pacemaker
- ❑ Yes ❑ No Implanted cardioverter defibrillator (ICD)
- ❑ Yes ❑ No Electronic implant or device
- ❑ Yes ❑ No Magnetically-activated implant or device
- ❑ Yes ❑ No Neurostimulation system
- ❑ Yes ❑ No Spinal cord stimulator
- ❑ Yes ❑ No Internal electrodes or wires
- ❑ Yes ❑ No Bone growth/bone fusion stimulator
- ❑ Yes ❑ No Cochlear, otologic, or other ear implant
- ❑ Yes ❑ No Insulin or other infusion pump
- ❑ Yes ❑ No Implanted drug infusion device
- ❑ Yes ❑ No Any type of prosthesis (eye, penile, etc.)
- ❑ Yes ❑ No Heart valve prosthesis
- ❑ Yes ❑ No Eyelid spring or wire
- ❑ Yes ❑ No Artificial or prosthetic limb
- ❑ Yes ❑ No Metallic stent, filter, or coil
- ❑ Yes ❑ No Shunt (spinal or intraventricular)
- ❑ Yes ❑ No Vascular access port and/or catheter
- ❑ Yes ❑ No Radiation seeds or implants
- ❑ Yes ❑ No Swan-Ganz or thermodilution catheter
- ❑ Yes ❑ No Medication patch (Nicotine, Nitroglycerine)
- ❑ Yes ❑ No Any metallic fragment or foreign body
- ❑ Yes ❑ No Wire mesh implant
- ❑ Yes ❑ No Tissue expander (e.g., breast)
- ❑ Yes ❑ No Surgical staples, clips, or metallic sutures
- ❑ Yes ❑ No Joint replacement (hip, knee, etc.)
- ❑ Yes ❑ No Bone/joint pin, screw, nail, wire, plate, etc.
- ❑ Yes ❑ No IUD, diaphragm, or pessary
- ❑ Yes ❑ No Dentures or partial plates
- ❑ Yes ❑ No Tattoo or permanent makeup
- ❑ Yes ❑ No Body piercing jewelry
- ❑ Yes ❑ No Hearing aid
  (Remove before entering MR system room)
- ❑ Yes ❑ No Other implant _____
- ❑ Yes ❑ No Breathing problem or motion disorder
- ❑ Yes ❑ No Claustrophobia

Please mark on the figure below the location of any implant or metal inside of or on your body.



IMPORTANT INSTRUCTIONS

Before entering the MR system room, you will be asked to change into a gown. Please understand that this is a safety requirement and not optional. You must remove all metallic objects including hearing aids, dentures, partial plates, keys, beeper, cell phone, eyeglasses, hair pins, barrettes, jewelry, body piercing jewelry, and watch.

NOTE: You may be advised or required to wear earplugs or other hearing protection during the MR procedure to prevent possible problems or hazards related to acoustic noise.

Please consult the MRI Technologist if you have questions or concerns before you enter the MR Suite.

I have read and understood and hereby consent to this MRI examination. I understand the use of contrast material may be recommended by my doctor for this exam.

Patient Signature_____Date:_____

I have reviewed and discussed these safety items with the above signed patient or guardian and approve this patient for magnetic resonance imaging.

Technologist Signature: _____ Date: _____

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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