Patient Acknowledgments, Authorization and Releases

Patient Number: _____ **<PIISF Personnel Only>**

Patient Name: _____

Date of Birth: _____

Social Security #: _____

Assignment of Benefits

Patient Initial: _____

I, <first, last, middle initial>_____, assign the benefits of my medical insurance coverage from <Plan Name>_____, policy # _____ _____ to PET Imaging Institute of South Florida, the proceeds of which are applicable to changes subsequent to medical treatment extended to me on _____.

This assignment of benefits also grants to PET Imaging Institute of South Florida the right to pursue any appeals with my insurance carrier necessary to secure full policy benefits.

Payment Policy

Patient Initial: _____

When scheduling your exam we explained to you that we will make every effort to collect the fee for today's visit from your insurance company. Based on the conversation we had with your insurance company on your behalf, we believe that your test is covered as described below. However, not all insurance companies currently reimburse for all Positron Emission Tomography or Computerized Tomography procedures even when they have been properly authorized.

Therefore, unless a specific alternative payment plan is agreed upon and documented in writing between us prior to having your procedure; payment in full for your study is ultimately your responsibility. If your insurance company fails to pay any portion (or all) of the amount owed to us within 90 days from the date of your exam, we will bill you directly for the outstanding balance. By signing this form you agree that you will pay the remaining balance in full upon receipt of our bill.

I have read the above payment policy and understand that after 90 days, I am responsible for any amount outstanding and unpaid. Because PET Imaging Institute of South Florida is doing me the courtesy of billing my insurance company directly, by signing below I further agree to allow all benefits payable for today's services to be paid directly to PET Imaging Institute of South Florida. I authorize PIISF to release all information necessary to secure payment of benefits. I authorize the use of this signature on all of my insurance submissions.

Release of Information Authorization

Patient Initial: _____

Please understand that insurance carriers frequently request information regarding your medical records in order to process your insurance claim. By signing this form you hereby authorize the PET imaging Institute of South Florida to release such information. I permit copy of this authorization to be used in place of the original, and request payment be made to the healthcare provider.

Patient Rights and Responsibilities Verification of Receipt & Acknowledgement

Patient Initial: _____

I have received and read the Patients Rights and Responsibilities document and understand its content.

Pregnancy Verification Statement

Patient Initial:

_____

I have been interviewed by a member of the PET Imaging Institute of South Florida Professional Staff. I was questioned regarding the possibility of being pregnant. It has been more than 10 days since the onset of my menstrual cycle.

I understand that I have been asked to verify that there is no chance that I could be pregnant; and that I have been asked this as a matter of proper patient care. It has been explained to me that this test involves being given a small amount of radioactive tracer and that this material is not routinely given to pregnant or potentially pregnant persons.

I certify that I am not pregnant.

Authorization for Release of Medical Records

From: PET Imaging Institute of South Florida

To: _____

Address: _____

I authorize you to furnish PET Imaging Institute of South Florida and all medical records and other documentation in your possession regarding my care and treatment.

I understand these records may contain information from other health care providers, as well as information, which is administrative in nature. I specifically consent to the release of any information contained in the medical record which may relate to infection with human immunodeficiency virus (HIV), AIDS, or related records.

I authorize you to transmit this information by facsimile transmission (**medical records**). I authorize you to release the information personally (**films**) to an authorized representative of PET Imaging Institute of South Florida is deemed necessary.

I release you from any liability for breech of confidentiality, misdirection or transmission, or failure to receive transmission if my records are transmitted by fax.

This release is valid until revoked by written notice to PET Imaging Institute of South Florida. I hereby waive any privilege I may have to said information. I have read and fully understand this Authorization for the Release of Medical Records. All blank statements requiring completion were filled in before I signed this Authorization for the Release of Medical Records.

_____

Signature of Patient or Guardian Date

Authorization for Release of Medical Records from PET Imaging to Other Individuals

Patient Name: _____
Patient Number: _____
SSN: _____
Date of Birth: _____
Phone # we can contact you at: _____

I request and authorize:

PET Imaging Institute of South Florida
1150 North 35th Avenue, Suite 665
Hollywood, FL 33021
Phone: 954-981-6668
Fax 954-981-5944

PET Imaging Institute of South Florida
603 N. Flamingo Road, Suite 155
Pembroke Pines, FL 33028
Phone: 954-981-6668
Fax 954-981-5944

To release healthcare information on the above patient for the purpose of:

- Continued health care or treatment
- Other: _____

To the following party:

Name _____ Phone ( ) _____-_____
Address _____ Fax ( ) _____-_____
City/State _____ Zip Code _____

Information to be released:

Current Medical records

This authorization will expire

on [date] _____ /_____ / _____ or upon [event] _____ and no later than 90 days after the date it was signed. This authorization may be revoked at any time by the patient in writing, providing the information has not already been disclosed. PET Imaging Institute of South Florida will not condition treatment or the provision of care on the completion of this authorization. This information should not be re-disclosed by the recipient without the patient's additional authorization or consent unless required by law.

_____

Signature of Patient or Guardian Date

Attestation of Identity

I, **<full name>**_____, attest that I am seeking care on my own behalf and am not fraudulently seeking Medicare-reimbursed services. I also affirm my identity based on the identification produced.

_____

Signature of Patient or Guardian Date