Women's Center For Radiology

1621 N. Mills Ave
Orlando, FL 32803
Phone: 4078410822
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PATIENT INFORMATION FORM

Last Name:			First Name:		Middle Name:
Pt.ID #:	DOB:	Age:	SSN:	Gender:	
Address:					
City:			State:		Zip Code:
Home Phone:			Work Phone:		Cell Phone:

EMERGENCY CONTACT INFORMATION

Name:	Relation:	Cell Phone:

PERSON RESPONSIBLE FOR BILL, IF NOT PATIENT

Last Name:	First Name:	Middle Name:
Relation:		Cell Phone:

Primary Insurance

For Medicare Patients: Are You or Your Spouse Working?:	☐ YES	☐ NO	If Yes, whom?
Primary Insurance Name:			Plan Name:
Address:			
City:	State:		Zip:
Policy #:	Group #:		DOB:
Policy Holder Name:			Sex:
Policy Holder Address:			
City:	State:		Zip:
Patient's Relationship to Policy Holder:			

Secondary Insurance

For Medicare Patients: Are You or Your Spouse Working?:	☐ YES	☐ NO	If Yes, whom?
Secondary Insurance Name:			Plan Name:
Address:			
City:	State:		Zip:
Policy #:	Group #:		DOB:
Policy Holder Name:			Sex:
Policy Holder Address:			
City:	State:		Zip:
Patient's Relationship to Policy Holder:			

ASSIGNMENT OF BENEFITS

- I, as patient or legal guardian of patient, consent to any services rendered on the instruction of the ordering physician.
- Payment is required at the time of service; if you supply all information needed today, we will bill your primary insurance. This does not waive your responsibility for payment. Whether you have health insurance coverage or not, professional services are rendered and charged to the patient. You (or the responsible party in the case of a minor) are responsible for payment of your bill if not covered in full or in part by your insurance.
- I will be responsible for late fees, collection charges or attorney fees incurred to obtain monies owed.
- I authorize this office to release information to pay physician and/or insurance company for claims processing. I also authorize payment directly to **Women's Center for Radiology, PA** for any and all services I have received or may receive in the future of all benefits for which I may be eligible including but not limited to insurance benefits. This authorization in no way waives my responsibility for full payment of all services received. This authorization shall remain in effect until revoked in writing by me.
- I acknowledge that the only health insurance coverage I have is listed above.

TREATMENT CONSENT: I am consenting to the provision of any medically necessary tests or procedures to be performed on this date.

I have read, fully understand and agree to the above statement(s).

_____ _____

SIGNATURE (PATIENT / PARENT / LEGAL GUARDIAN) **DATE**

Patient HIPAA Consent

Consent for the use and disclosure of health information for treatment, payment or healthcare purposes.

I have obtained, read and understand the **Notice of Privacy Practices** for **Women's Center for Radiology, PA**, which provides a complete description of information uses and disclosures.

I understand that:

- As a part of my healthcare, **Women's Center for Radiology, PA** originates and stores paper and/or electronic records pertaining to my health care and health history, including symptoms, examination and test results, diagnoses and treatment.
- I may revoke this consent, in writing, at any time with the exception of actions already taken. By refusal to sign or revoking of this consent form may result in dismissal of care or treatment as permitted by Section 164.506 in the Code of Federal Regulations.
- **Women's Center for Radiology, PA** reserves the right to change their **Notice of Privacy Practices** at any time as permitted by Section 164.520 in the Code of Federal Regulations.
- It may be necessary for the organization to disclose my protected health information to another entity for treatment, healthcare or billing and payment purposes and I allow **Women's Center for Radiology, PA** to disclose this information to those entities.

I fully understand and accept the terms of this Patient HIPAA Consent Form. I acknowledge that I have received the **Notice of Privacy Practices** from **Women's Center for Radiology, PA** and have had any and all questions regarding these forms answered by the undersigned employee.

PRIVACY NOTICE: I acknowledge I have been given the opportunity to read and receive a copy of the **Women's Center for Radiology, PA Notice of Privacy Practices** that explains to me how **Women's Center for Radiology, PA** will use and disclose my information. I understand that **Women's Center for Radiology, PA** does not need my permission to disclose health information for purposes related to treatment, payment, or routine business operations.

Print: _____ **Sign:** _____ **Date:** _____

RELEASE OF MEDICAL RECORDS: By signing this form, I hereby authorize release of my medical records, inclusive of all test results and pertinent information acquired during my treatment, to/from other physicians and healthcare providers. In addition, I understand that I have the right to request a copy of my medical record, or a portion thereof, at any time, and that **Women's Center for Radiology, PA** will do its best to respond to my request at the time of the request or as reasonably soon thereafter. I acknowledge and understand that I may incur fees associated with the copying of such medical records.

In addition, by signing below, I hereby authorize the release and disclosure of my medical information to the following individuals:

_____ _____ _____ _____

(Name) **(Relationship)** **(Name)** **(Relationship)**

This authorization extends to all of my protected health information that is disclosed for general information purposes and is valid until revoked. The information that may be disclosed includes but is not limited to: statements of charges or payments, records of visits for any and all dates, copies of records or reports provided to other physicians or providers, history and physical examination reports, and consultation reports. I understand that I may revoke this authorization at any time, except where information has already been released. The revocation must be in writing and sent to Attention: Privacy Office, **1718 N. Mills Ave. Orlando, Fl 32803 Women's Center for Radiology, PA**, its employees, officers, and physicians are hereby release from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

_____ _____

SIGNATURE (PATIENT / PARENT / LEGAL GUARDIAN) **DATE**

_____

PRINTED NAME

The following person(s) are authorized to receive information about my medical condition, treatment, status or test results. This authorization remains in effect unless canceled in writing by the patient.

_____

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