BEACHES OPEN MRI

# PATIENT INFORMATION

**Name:** _____ **Date of Birth:** _____

**Social Security #:** _____ **Email:** _____

**Home #:** _____**Work #:** _____ **Other #:** _____

**Home Address:** _____

**City/State:** _____ **ZIP:**_____

**Referring Physician:** _____ **Follow up Appointment:** _____

**Primary Insurance:** _____ **Secondary Insurance:** _____

**Name of Insured (if other than Pt):** _____ **DOB:** _____

**Is this injury related to an auto accident: Yes_____ No_____**

**Auto Insurance Carrier:** _____

**Date of accident:** _____ **Claim number:** _____

**Do you have an attorney? Yes ____ No_____**

**If yes, please list:** _____ **Attorney phone:** _____

**How did you hear about us?** _____

**By signature below, I understand that Beaches Open MRI (hereinafter BOMRI) has agreed to provide me (patient or patient's guardian) with the important health care imaging service ordered by my doctor, even if my insurance company has denied, delayed or failed to authorize the service. I further recognize that BOMRI will do everything possible with my doctor to convey the importance and necessity of the imaging service to my insurance company, but I understand and agree that I am ultimately financially responsible for any cost my insurance company denies or does not pay for any reason. In addition, I authorize payment of medical benefits directly to BOMRI. This assignment includes but is not limited to all rights to collect benefits directly from my insurance company or HMO for those services I have received and all rights to proceed against my insurance company or HMO in any action including legal suit if for any reason my insurance company or HMO fails to make payments of benefits that are due to BOMRI. This assignment also includes the right to recover any attorney fees and costs for such action brought by BOMRI as my assignee. If I have requested that my insurance company hold my benefits for lost wages, I hereby release those amounts necessary to pay for services provided by BOMRI. Furthermore, I direct my attorney to withhold funds and pay BOMRI directly for the imaging services they have provided, from any recovery I may have. I understand that BOMRI will file my insurance claim as a courtesy to me, and that any amounts not covered by my insurance will be paid by me. If your account goes unpaid for 90 days, we may turn your account over to a collection agency for more intense collection efforts and a 40% fee will be added to the bill to cover these costs. I authorize BOMRI to release any and all information requested by any insurance company billed, in order to complete my insurance claim.**

**Signature:_____ Date: _____**

**Please PRINT your name:_____**

Please print this form, complete it in its entirety, and bring it with you at the time of your visit to Beaches Open MRI.
DO NOT send this form electronically.

**350 10th AVENUE SOUTH • JACKSONVILLE BEACH, FL 32250 • 904-247-2220 PHONE • 904-247-2296 FAX**

BEACHES OPEN MRI

# BONE DENSITY PATIENT HISTORY

NAME: _____ DATE: _____

SSN: _____ DATE OF BIRTH: _____ MALE _____ FEMALE _____

PHYSICIAN: _____ HEIGHT: _____ WEIGHT: _____

PREVIOUS BONE DENSITY? Y _____ N _____ If yes, when? _____

RACE: Caucasian ____ African-American ____ Hispanic ____ Asian ____ Other ____

Is there a family history of osteoporosis? Y ____ N ____

Have you ever had a broken bone? Y ____ N ____
If yes, which one, and when? _____

Have you ever had surgery? Y ____ N ____
If yes, what type? _____

Do you smoke? Y ____ N ____ If yes, how much? _____

Do you consume alcoholic beverages? Y ____ N ____
If yes, how much? _____

Do you take calcium supplements? Y ____ N ____
If yes, how much? _____

HAVE YOU EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING CONDITIONS?

| | | | |
|---|---|---|---|
| Osteoporosis | _____ | Parkinson's disease | _____ |
| Hyperthyroidism | _____ | Partial/complete paralysis | _____ |
| Kidney disease | _____ | Intestinal disease | _____ |
| Amenorrhea | _____ | Arthritis | _____ |

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:

_____

_____

_____

********** FEMALE PATIENTS ONLY **********

Have you gone through menopause, and if so, when? _____
Did you have a hysterectomy? _____ Complete or partial? _____
Are you or have you ever taken hormones? _____

********** TECHNOLOGIST ONLY **********

_____

_____

# AUTHORIZATION FOR MEDICAL RECORDS / FILMS RELEASE

**I, _____**

**DOB:_____**

**Signed:_____ Date:_____**
**Patient/Guardian**

**I voluntarily give my authorization to use or disclose my protected health information to assist with my treatment to/from:**

*******************OFFICE USE ONLY BELOW THIS LINE******************

**Release of Records from:**

**Name:_____**

**Address:_____**

**_____**

**Phone/Fax: (  ) _____**

**(  ) _____**

- **Send my requested records to**:

  **Beaches Open MRI**
  **350 10th Avenue South**
  **Jacksonville Beach, FL. 32250**
  **(904) 247-2220  (904) 247-2296 FAX**

BEACHES OPEN MRI

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name:

_____

I hereby acknowledge that I have received a copy of Beaches Open MRI's Notice of Privacy Practices. I understand that I have the right to refuse to sign this acknowledgement if I so choose. I also hereby authorize Beaches Open MRI to use and/or disclose my protected health information as I have authorized below.

Do we have permission to:

1) Leave a message on your answering machine at home? YES NO
2) Leave a message at your place of employment? YES NO
3) Discuss your medical information to other members of your household or family? YES NO

   If "YES", to whom? _____
   _____
4) Have films, reports and billing information available to other members of your household or family? YES NO

   If "YES", to whom? _____
   _____

_____ _____
Signature of Patient or Legal Representative Date

_____
Printed Name of Patient's Representative ( if applicable)

Relationship to Patient (if applicable)
□ Parent or guardian of unemancipated minor
□ Court appointed guardian
□ Executor or administrator of decedent's estate
□ Power Of Attorney

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FOR OFFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices on following date, _____ but acknowledgement could not be obtained because:

□ Patient/representative refused to sign
□ Emergency situation prevented us from obtaining acknowledgement at this time (will attempt again at a later date)
□ Communication barriers prohibited obtaining acknowledgement (Explain)

_____

_____

□ Other (Specify)
_____

_____

BEACHES OPEN MRI

# NOTICE OF PRIVACY PRACTICES

**EFFECTIVE DATE:** April 14, 2003

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

## UNDERSTANDING YOUR HEALTH RECORD/INFORMATION

Each time you visit a hospital, radiologist, physician, dentist, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information often referred to as your health or medical record, serves as a basis for planning your care and treatment and serves as a means of communication among the many health professionals who contribute to your care. Understanding what is in your record and how your health information is used helps you to ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and helps you make more informed decisions when authorizing disclosure to others.

## YOUR HEALTH INFORMATION RIGHTS

Unless otherwise required by law, your health record is the physical property of the healthcare practitioner or facility that compiled it. However, you have certain rights with respect to the information. You have the right to:

1. **Receive a copy of this Notice of Privacy Practices** from us upon enrollment or upon request.
2. **Request restrictions on our uses and disclosures of your protected health information** for treatment, payment and health care operations. However, we reserve the right not to agree to the requested restriction.
3. **Request to receive communications of protected health information in confidence.**
4. **Inspect and obtain a copy of the protected health information** contained in your medical and billing records and in any other Practice records used by us to make decisions about you. A reasonable copying charge may apply.
5. **Request an amendment to your protected health information**. However, we may deny your request for an amendment, if we determine that the protected health information or record that is the subject of the request:
   - was not created by us, unless you provide a reasonable basis to believe that the originator of the protected health information is no longer available to act on the requested amendment;
   - is not part of your medical or billing records;
   - is not available for inspection as set forth above; or
   - is accurate and complete.

   In any event, any agreed upon amendment will be included as an addition to, and not a replacement of, already existing records.
6. **Receive an accounting of disclosures of protected health information** made by us to individuals or entities other than to you, except for disclosures:
   - to carry out treatment, payment and health care operations as provided above;
   - to persons involved in your care or for other notification purposes as provided by law;
   - to correctional institutions or law enforcement officials as provided by law;
   - for national security or intelligence purposes;
   - that occurred prior to the date of compliance with privacy standards (April 14, 2003);
   - incidental to other permissible uses or disclosures;
   - that are part of a limited data set (does not contain protected health information that directly identifies individuals);
   - made to patient or their personal representatives;
   - for which a written authorization form from the patient has been received
7. **Revoke your authorization to use or disclose health information** except to the extent that we have already been taken action in reliance on your authorization, or if the authorization was obtained as a condition of obtaining insurance coverage and other applicable law provides the insurer that obtained the authorization with the right to contest a claim under the policy.

## HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED

This organization may use and/or disclose your medical information for the following purposes:

**Treatment:** We may use and disclose protected health information in the provision, coordination, or management of your health care, including consultations between health care providers regarding your care and referrals for health care from one health care provider to another.

**Payment:** We may use and disclose protected health information to obtain reimbursement for the health care provided to you, including determinations of eligibility and coverage and other utilization review activities.

**Regular Healthcare Operations:** We may use and disclose protected health information to support functions of our practice related to treatment and payment, such as quality assurance activities, case management, receiving and responding to patient complaints, physician reviews, compliance programs, audits, business planning, development, management and administrative activities.

**Appointment Reminders:** We may use and disclose protected health information to contact you to provide appointment reminders.

**Treatment Alternatives**: We may use and disclose protected health information to tell you about or recommend possible treatment alternatives or other health related benefits and services that may be of interest to you

**Health-Related Benefits and Services:** We may use and disclose protected health information to tell you about health-related benefits, services, or medical education classes that may be of interest to you.

**Individuals Involved in Your Care or Payment for Your Care:** Unless you object, we may disclose your protected health information to your family or friends or any other individual identified by you when they are involved in your care or the payment for your care. We will only disclose the protected health information directly relevant to their involvement in your care or payment. We may also disclose your protected health information to notify a person responsible for your care (or to identify such person) of your location, general condition or death.

**Business Associates:** There may be some services provided in our organization through contracts with Business Associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose some or all of your health information to our Business Associate so that they can perform the job we have asked them to do. To protect your health information, however, we require the Business Associate to appropriately safeguard your information.

**Organ and Tissue Donation:** If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

**Worker's Compensation:** We may release protected health information about you for programs that provide benefits for work related injuries or illness.

**Communicable Diseases:** We may disclose protected health information to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

**Health Oversight Activities:** We may disclose protected health information to federal or state agencies that oversee our activities.

**Law Enforcement:** We may disclose protected health information as required by law or in response to a valid judge ordered subpoena. For example in cases of victims of abuse or domestic violence; to identify or locate a suspect, fugitive, material witness, or missing person; related to judicial or administrative proceedings; or related to other law enforcement purposes.

**Military and Veterans:** If you are a member of the armed forces, we may release protected health information about you as required by military command authorities.

**Lawsuits and Disputes:** We may disclose protected health information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process.

**Inmates:** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release protected health information about you to the correctional institution or law enforcement official. An inmate does not have the right to the Notice of Privacy Practices.

**Abuse or Neglect:** We may disclose protected health information to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

**Fund raising:** Unless you notify us you object, we may contact you as part of a fund raising effort for our practice. You may opt out of receiving fund raising materials by notifying the practice's privacy officer at any time at the telephone number or the address at the end of this document. This will also be documented and described in any fund raising material you receive.

**Coroners, Medical Examiners, and Funeral Directors:** We may release protected health information to a coroner or medical examiner. This may be necessary to identify a deceased person or determine the cause of death. We may also release protected health information about patients to funeral directors as necessary to carry out their duties.

**Public Health Risks:** We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose such as controlling disease, injury or disability.

**Serious Threats:** As permitted by applicable law and standards of ethical conduct, we may use and disclose protected health information if we, in good faith, believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

**Food and Drug Administration (FDA):** As required by law, we may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

**Research (inpatient):** We may disclose information to researchers when an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information has approved their research.

**OUR RESPONSIBILITIES**

We are required to maintain the privacy of your health information. In addition, we are required to provide you with a notice of our legal duties and privacy practices with respect to information we collect and maintain about you. We must abide by the terms of this notice. We reserve the right to change our practices and to make the new provisions effective for all the protected health information we maintain. If our information practices change, a revised notice will be mailed to the address you have supplied upon request. If we maintain a Web site that provides information about our patient/customer services or benefits, the new notice will be posted on that Web site. Your health information will not be used or disclosed without your written authorization, except as described in this notice. Except as noted above, you may revoke your authorization in writing at any time.

**FOR MORE INFORMATION OR TO REPORT A PROBLEM**

If you have questions about this notice or would like additional information, you may contact our Privacy Officer at the telephone or address below. If you believe that your privacy rights have been violated, you have the right to file a complaint with the Privacy Officer at Beaches Open MRI or with the Secretary of the Department of Health and Human Services. We will take no retaliatory action against you if you make such complaints.

The contact information for both is included below.

**U.S. Department of Health and Human Services**
Office of the Secretary
200 Independence Avenue, S.W.
Washington, D.C. 20201
Tel: (202) 619-0257
Toll Free: 1-877-696-6775
http://www.hhs.gov/contacts

**Beaches Open MRI**
Mark Sanford, Privacy Officer
350 10th Avenue South
Jacksonville Beach, FL 32250
Phone: 904-247-2220
Fax: 904-247-2296

**NOTICE OF PRIVACY PRACTICES AVAILABILITY**

This notice will be prominently posted in the office where registration occurs. You will be provided a hard copy, at the time we first deliver services to you. Thereafter, you may obtain a copy upon request, and the notice will be maintained on the organization's Web site (if applicable Web site exists) for downloading.