PATIENT REGISTRATION FORM

National Imaging Specialists
6600 66th Street North
Suite B
Pinellas Park, Florida 33781
Phone: (727) 544-1001
Fax: (727) 471-2197

National Imaging Specialists (VyMed)
10010 N. Dale Mabry Highway
Suite 160
Tampa, Florida 33618
Phone: (813) 264-7176
Fax: (813) 264-7161

Patient Information: *(Please complete all information)*	Authorization #:		MR ID#:
Patient Name: *(Last)* *(First)* *(Middle)*	DOB:	SSN:	Sex: ☐ Male ☐ Female
Address: *Street* *City* *State* *Zip*			Home Phone:
Marital Status: ☐ Married ☐ Single ☐ Other	Ht:	Wt:	Employment: ☐ Full Time ☐ Part Time ☐ Student ☐ Other
Insured's Employer:	Contact Person:		Office Phone:
Employer Address: *Street* *City* *State* *Zip*			Fax Phone:
Emergency Contact:	Relationship		Phone:
Guarantor/Parent/Legal Guardian Information:	Name:		SSN: *(if different from patient)*
Address:	Phone:		Employer:
Medical Information:	Diabetic? ☐ Yes ☐ No	Are you pregnant? ☐ Yes ☐ No	Have a Pacemaker? ☐ Yes ☐ No
Current symptoms/Reason for Procedure:			Date of onset of symptoms:
Referring Physician Name: *(Last)* *(First)*			Specialty:
Address: *Street* *City* *State* *Zip*		Phone No.:	Fax No.:
Primary Care Physician Name:		Phone No:	Fax No.:

Please read below, complete information and sign.

Primary Insurance	Secondary Insurance
Co. Name:_____	Co. Name:_____
Address: _____	Address: _____
City _____ State _____ Zip _____	City _____ State _____ Zip _____
Phone No: _____ Fax No: _____	Phone No: _____ Fax No: _____
Member ID#: _____Group #:_____	Member ID#: _____Group #:_____
Insured Name: _____	Insured Name: _____
Relationship: _____	Relationship: _____
SSN#:_____ DOB: _____	SSN#:_____ DOB: _____

INSURANCE / MEDICARE WAIVER OF LIABILITY FORM

Provider Name:	Provider Address:
Patient Name:	Medicare No.:

Insurance providers reserve the right to pay only for services they determine reasonable and necessary. Additionally, Medicare will pay only for services that it determines to be "reasonable and necessary" under Section 1862(a)(1) of the Medicare Law. If Medicare determines that a particular service, although it would otherwise be covered, is not "reasonable and necessary" under Medicare program standards, Medicare will deny payment for that service.

Your physician feels that the service listed below is in your medical interest. There is a possibility that Medicare or your insurance provider will deny payment for this service.

My Physician has notified me that there is a possibility that payment may be denied for the service identified below.
If payment is denied, I agree to be personally and fully responsible for payment.

Patient Signature:	Date:
Service to be Performed:	Diagnosis Code:

Are you currently living in a Skilled Nursing Facility?

☐ No ☐ Yes _____
Name of Facility

Patient Signature:	Date:

NIS Form # 1904

PATIENT AUTHORIZATION

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PLEASE READ, INITIAL AND SIGN

PLEASE INITIAL All SECTONS THAT APPLY TO YOU AS AN INDICATION THAT YOU HAVE READ AND UNDERSTAND THE INFORMATION AND THAT YOU AGREE TO IN AUTHORIZATIONS STATED BELOW. IF YOU HAVE ANY QUESTIONS, ONE OF OUR STAFF WILL BE HAPPY TO ASSIST YOU.

_____ **ASSIGNMENT OF BENEFITS:** I hereby authorize payment directly to National Imaging Specialists / VyMed of any and all medical benefits applicable and otherwise payable to me. I understand that I am financially responsible to National Imaging Specialists / VyMed for charges not covered by this assignment.

_____ **RELEASE OF INFORMATION:** I hereby authorize National Imaging Specialists / VyMed to furnish my insurance company or companies, workers compensation carrier, my physician, a physician or hospital requesting information, my employer or rehabilitation practitioner or their representatives with any and all information that may be contained in my medical records that relate to procedure(s) performed at any National Imaging Specialists / VyMed imaging center.

_____ **AUTHORIZATION TO OBTAIN MEDICAL RECORDS:** I hereby authorize any healthcare provider to release my healthcare information, including but not limited to, films, reports, physical assessments, diagnostic test results, postoperative reports and implanted device information, if any, as requested by National Imaging Specialist / VyMed or its affiliates.

_____ **LIFETIME MEDICARE B SIGNATURE AUTHORIZATION:** I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers, or the billing agent of National Imaging Specialists / VyMed, any information needed for this or any related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical benefits be made to the holder of this assignment on my behalf. I understand that I am responsible for any required deductibles and coinsurance.

_____ **MEDIGAP:** I request that payment of authorized MEDIGAP benefits be made on my behalf to National Imaging Specialists / VyMed for any services furnished to me at any National Imaging Specialists / VyMed imaging center. I authorize any holder of medical information about me to release to National Imaging Specialists / VyMed any information needed to determine these benefits or benefits payable for related services. I understand that I do not need to provide my supplemental insurer with information concerning this Medicare claim, because my signing of this authorization will cause Medicare payments to cross over automatically.

Name of Insured: _____ MEDIGAP Policy: _____
(Please Print)

Policy Number: _____

_____ **IF PATIENT IS UNDER 18:** I hereby give my permission for _____ to receive services rendered at this National Imaging Specialists / VyMed Center.

_____ _____ _____ _____
Signature Patient / Parent / Guardian | Date | Witness | Date

Relationship: _____ Patient ID# _____

PATIENT RIGHTS AND RESPONSIBILITIES

National Imaging Specialists / VyMed

1) You have the right to receive reasonable and fair medical treatment without regard to race, color, creed, national origin, age, sex, handicap or source of payment.
2) You have the right to thoughtful and respectful care at all times. You have the right to expect all records regarding your care including payment source will be kept confidential by law.
3) You have the right to expect reasonable safety with regard to this Center's practices and environment.
4) You have the right to know what support services are available including a translator if you do not speak English.
5) As a patient eligible for Medicare, you have the right upon request and prior to treatment to know if this Center accepts Medicare assignment
6) A patient has the right to emergency medical treatment for any medical condition that will deteriorate if care is not given.
7) A patient has the right to receive prompt and reasonable response to any questions or request.
8) A patient has the right to know by name, anyone who is providing the medical service and is responsible for their care.
9) A patient has the right to be given by the healthcare provider any information concerning diagnosis, course of treatment, alternatives, risks, and prognosis.
10) A patient has the right to refuse treatment except as otherwise provided by law.
11) A patient has the right, upon request, to be given information and counseling on the availability of known financial resources for patient's care.
12) A patient has the right to request, prior to treatment, a reasonable estimate of charges related to his or her care.
13) A patient has the right to an understandable, itemized bill, a reasonable estimate of charges related to his or her care.
14) A patient has the right to be informed of the health care provider's rules and regulations, your patient rights and regulations, that apply to your conduct and to access the providers system for presenting complaints regarding service or quality of care.
15) You have the right as a newborn child or adolescent to have all the rights of any patient expressed by your legal guardian/custodian. Consent for treatment must be obtained from that legal guardian if a patient is under eighteen years of age. Any doctor, however, may give emergency care without consent to any patient who has been injured in an accident, suffers an acute illness, disease or condition, if delayed medical care would endanger the health or life of this patient under the age of eighteen.
16) You have the right to refuse to participate in any medical education or research projects. Any medical treatment considered to be experimental will be made know to you in advance.
17) You have the right to request a second opinion from another doctor, at your own expense.
18) You have the right to report any accused or suspected abuse or neglect to Administration and to receive a quick and reasonable response.
19) You have the right express complaints regarding any violation of your rights as stated in Florida law through the grievance procedure of the Center and to the appropriate state licensing agency.
20) You have the right to make decisions about your care or select another person to make your decisions in the event you are unable.

Patient Signature: _____

INFORMED CONSENT – CT

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1) I request and authorize the performance of a Computed Tomography Imaging (CTI) procedure for myself: _____ as ordered by my referring physician.

2) Preparation varies depending on the CT exam you are having. You may be given contrast media to highlight a certain body area.

3) It is important to drink the entire amount of oral contrast at the designated times to ensure that your exam is complete.

4) When you enter the exam room, you will be asked to lie on the scanner table. A radiologic technologist will assist you into the correct position. The table will then be moved into the scanner's opening to perfectly align the portion of your head or body to be studied. After each image is taken, the table will advance slightly to scan the next portion.

5) As you are moved through the scanner, relax and remain as still as possible. If a scan of your chest or abdomen is being done, you will be asked to hold your breath with each picture. This is to avoid blurring the image that could be caused by breathing. Each picture takes only seconds to complete. The technologist will tell you when to breathe.

6) Your CT exam usually averages between 15 and 30 minutes.

7) You may resume regular diet and medication schedule immediately after the exam, unless your physician has advised you differently.

8) A radiologist will review your CT scan. The radiologist will then report the results to your physician, who will discuss the findings with you.

9) If you have an allergy to iodine or have had an allergic reaction to a previous contrast (dye) exam, please tell the technologist before having this exam.

10) Any woman who is pregnant or suspects she may be pregnant should please let the technologist know before undergoing the CT scan.

11) You will be asked to remove your watch and jewelry. A small locker will be provided for your valuables.

12) I acknowledge that no statement or guarantee has been made to me regarding the anticipated results of this procedure.

13) Images or clinical data from this procedure may be used for scientific or educational purposes in accordance with customary medical practice.

14) I authorize transmission of my images and reports via email, other electronic means or other means to my referring physician or other physicians involved in my care.

15) You agree to allow us access to your medical records and do other radiologic examinations for purposes of comparison.

16) I have had the opportunity to have any questions or concerns explained and addressed and have no unanswered questions or concerns at this time.

_____ _____
Signature of Patient or Authorized Representative **Date**

_____ _____
Technologists or Physician **Date**

Patient ID# _____