Demographics

Patient Name: _____ Gender: Male Female

Social Security#_____-_____-_____ Marital Status: _____ Date of birth: _____/_____/_____

Race: __Decline __American Indian or Alaska Native __Asian __Black or African American
__Native Hawaiian or Other Pacific Islander __White ___Other Race

Ethnic: __Decline __ Hispanic ___Non Hispanic

Address: _____
Street Apt #

_____
City State Zip code
Phone: (_____) _____--_____ Cell: (_____)_____--_____ Work: (_____) _____--_____ ext:_____

Email:_____

Emergency Contact:_____ Relationship*_____ Phone: (_____)_____--_____

We must have all insurance and policy holder information to submit your claim. If this visit is related to a Motor Vehicle Accident please provide any Health Insurance information so we can submit any remaining balance to them.

Primary Insurance _____ Insurance ID _____

Policy Holder Name _____ DOB _____ Social Security# _____

Secondary Insurance_____ Insurance ID _____

Policy Holder Name _____ DOB _____ Social Security#_____

Motor Vehicle Accident ***** PLEASE PROVIDE AND INFORM STAFF *IF* RELATED TO TODAYS VISIT *****

Auto Insurance Carrier_____Policy #_____

Claim#_____**Date of Accident**_____**Attorney**_____

Please note that sedation requires payment up front. Beach Medical Imaging, Beach Medical Specialist and Dr. Daniel K. Beirne II M.D. will gladly bill your Insurance Company for the sedation and refund you if payment is received.

I have read, understand and accept the terms of the Health Information Privacy Act (HIPAA)
The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician.
I understand that I am financially responsible for any balance. I also authorize Beach Medical Imaging, Beach Medical Specialist, Dr. Daniel K. Beirne II M.D. and my insurance company to release any information required to process my claim. I also understand that any no show or any cancellation with less than 24 hours notice there will be an office fee charge to the patient, the fee will be depending on the study.

_____ _____/_____/_____
Patient Signature **Date**

Minor Consent

I, _____ hereby authorize and give consent to Beach Medical Imaging, Beach Medical Specialist or Dr. Daniel K. Beirne II M.D. for all medical and/or surgical procedures that may be required for

_____.
Patient

_____
Parent or Guardian Signature Date

All Fields are required *

Screening Form

Patient Name: _____ Date of birth: _____/_____/_____ Gender Male Female

*Weight: _____ *Height: _____*what are your symptoms and Date they began:_____

_____

*What is the severity of your symptoms (Please check) None Mild Moderate Severe

*Is this related to a Motor Vehicle accident ? YES NO OR Related to Workers Compensation? YES NO

*Do you have any allergies of any kind (medicine, food, x-ray dye, others) YES NO If yes, please list below:

_____ What kind of reaction did you have? _____

***Please list ALL medications you are currently taking:**

_____ **Please indicate Past Medical History: HEARING AID &**

DENTAL WORK MUST BE REMOVED FOR IMAGING

Yes No Claustrophobic
Yes No Pacemaker (provide copy)
Yes No Cardiac Defibrillator(provide copy)
Yes No Stents in last 6 weeks
(for Cardiac Stents provide copy)
Yes No Generalized severe Debilitation
Yes No Heart Pacing Wiring
Yes No Congestive heart failure
Yes No Irregular Heart Beat
Yes No Recent (Heart Attack)
Yes No Other Heart Problems:
(Specify):_____
Yes No Hypertension (high blood pressure)
Yes No Multiple Myeloma(cancer in cells)
Yes No ABN fast ht rate
Yes No Chest Pain with shortness of breath (INFORM STAFF IMMEDIATELY)
Yes No Asthma / Hay fever (circle one)
Yes No Emphysema / COPD (circle one)
Yes No Nerve stimulator
Yes No Any type of Bio-stimulator
Yes No Brain Aneurysm Clips
Yes No Brain Stimulator
Yes No Ear or Eye Implant

Yes No Cochlear Implant
(Electronic hearing device NOT removable)
Yes No Orbital prosthesis(provide copy)
Yes No Hearing Aid (MUST BE REMOVED)
Yes No Cancer
(describe type):_____
Yes No Any metal implants (list below)
Yes No Implanted Insulin pump
Yes No Pain Rx Pump (removable ?)

Yes No Kidney disease
Yes No Sickle cell anemia
Yes No Diabetes
Yes No Taking Glucophage (Metformin)
Yes No Blood Thinners
Yes No are you Pregnant or Nursing
Yes No Permanent Make-up or any Tattoo (INK)
Yes No Labs done in 1 month
(Date and Place): _____

_____

*__When is your follow up with your referring Doctor?__ _____

*__Please list all prior surgeries and approximate dates__: _____

_____

*Have you had any previous imaging done __pertaining to the scan you are having done today?__ Yes No

Imaging Facility: _____City/State_____

Imaging test performed: _____ Date (Year) _____

Family Medical History: _____

Social History: Children Y N *Married Y N *Do you consume alcohol Y N * Do you use tobacco Y N

Job description: _____ Primary Physician:_____ Tel:_____-_____-_____

Please indicate any additional relevant medical information not previously listed (or changes since your previous visit:)

_____

I attest that all of the above information is correct to the best of my knowledge. I have read and understand. The entire contents of this form and I have had the opportunity to ask questions regarding the information on this form. It is my responsibility to inform Beach Medical Imaging, Beach Medical Specialist or Dr. Daniel K. Beirne II M.D. of any changes in my medical history.

_____ _____/_____/_____
Patient / Guardian Signature **Date**

Beach Medical Imaging
2033 South Patrick Drive
Indian Harbour Beach, FL 32937

ASSIGNMENT OF BENEFITS, POWER OF ATTORNEY AND RELEASE OF INFORMATION
Insurer please read the following, in its entirety upon receipt:

I, the undersigned patient/insured knowingly, voluntarily and intentionally assign the benefits of insurance and any over due interest payments under the policy of insurance from my insurer or the responsible insurer to the above described medical provider for any and all services rendered to the undersigned patient/insured. The patient understands it is the express intention of the provider to accept this assignment of benefits in lieu of demanding payment at the time services are rendered. The undersigned assigns any and all claims for statutory bad faith to the above medical provider. If the insurer disputes the validity of this assignment of benefits then the insurer is instructed to notify the provider in writing within five (5) days of receipt of this document. I understand this assignment will remain in full force and effect and will NOT be revoked unless the revocation is agreed to by both the medical provider and the undersigned patient or the patient's attorney. This assignment applies to both past and future medical expenses and is valid even if undated. A photocopy of this assignment is to be considered as valid as the original. The undersigned patient/insured directs the insurer to pay the medical provider directly without including the patient's name on the check.
The insurer is directed by the provider and the patient/insured to not issue any checks or drafts in partial settlement of a claim that contain or are accompanied by language releasing the insurer or its insured/patient from liability unless there has been a prior written settlement agreed to by the medical provider and the insurer as to the amount payable under the insurance policy or contract. The provider hereby objects to any reductions or partial payments made at the discretion of the insurer. Any partial or reduced payment regardless of the accompanying language, issued by the insurer and deposited by the provider shall be done so under protest, at the risk of the insurer, and the deposit shall not be deemed a waiver, accord, satisfaction, discharge, settlement or agreement by the provider to accept a reduced mount as payment in full. The insurer is hereby placed on notice that this provider reserves the right to seek the full amount of the bills submitted.
In the event the subject medical benefits are disputed by the insurer for any reason, including but not limited to, medical reasonableness and/or necessity, the undersigned patient/insured hereby instructs the insurer to set aside any amount disputed (i.e. to escrow the money) and not pay the disputed amount to anyone, including myself, or any entity until the dispute is resolved. The insurer is instructed to immediately explain in writing to the above provider of any dispute. If the insurer schedules an IME or EUO the insurer is hereby requested and authorized to send a copy of said notification to this provider. The provider is not the agent of the insurer or the patient for any purpose.
The undersigned patient/insured agrees to pay any applicable deductible or co-payments for services rendered after the policy of insurance exhausts, and for any other service unrelated to the automobile accident.

I give my permission to Beach Medical Imaging and their staff to release my medical information to the following people listed below:
_____

_____

Release of Information: I hereby authorize this medical provider to: furnish my insurance company or companies and the patient's attorney with any and all information that may be contained in my medical records; to obtain coverage information telephonically from my insurer; to request a written non-redacted PIP payout sheet from the insurer; and to obtain copies of my medical records, including but not limited to, documents, reports, scans, notes, opinions, X-rays, and MRI s, from any other medical provider or any insurance company. The insurer is directed to keep the patient's medical records private and confidential. The insurer is NOT authorized to provide these medical records to anyone, including but not limited to, third party vendors without the patient's and the provider's prior express written permission.

I certify that I have not been solicited or promised anything in exchange for receiving medical care or that I have received any promises or guarantees from anyone as to the results that may be obtained by any medical treatment.

Caution! Please read before signing. If you do not completely understand this document please ask us to explain it to you. If you sign below we will assume you understand and agree to the terms.

Patient or Guardian

Name (Print)_____ Date of Birth_____

Signature_____ Date_____