Authorization for Medical Services

1. **Legal Relationship Between Radiology Regional Center and Healthcare Practitioner.** Healthcare practitioners involved in your care may be employees or contractors of Radiology Regional Center. I understand that certain healthcare practitioners furnishing services to me on the premises of Radiology Regional Center may be independent contractors and are not employees or agents of Radiology Regional Center. I understand that in those cases, there may be a separate charge from these physicians and healthcare professionals for their services.
2. **Release of Information.** I authorize Radiology Regional Center and any healthcare practitioner involved in my care to release my medical information and supporting documents of same, as compiled in my medical record during this outpatient visit, in accordance with HIPAA 45 CFR Parts 160 & 164 unless otherwise prohibited by the completion of a "PHI Special Restriction Request" form by the patient or patient's representative. I acknowledge that data from my medical record may be accessible to all healthcare providers and their appropriate staff under the HIPAA treatment, payment and operations guidelines (TPO).
3. **Assignment of Benefits.** I agree to assign all right, title, and interest in all benefits payable for the healthcare rendered, which are provided in any and all insurance policies and health benefit plans from which my dependents or I are entitled to recover. The assignment of benefits allows Radiology Regional Center and/or its healthcare practitioners to be paid directly by my health insurance carrier or other health benefit plan, including Medicare, for the services Radiology Regional Center and/or its healthcare practitioners provide to me, my minor child, or other person(s) entitled to healthcare benefits for this date of service. The assignment and transfer shall be for the purpose of granting Radiology Regional and/or its healthcare practitioners an independent right of recovery against my insurer or health benefit plan, but shall not be construed as an obligation of Radiology Regional Center and/or its healthcare practitioners to pursue any such right of recovery. In cases where Radiology Regional Center takes assignment, patient payment obligations remain for deductible, co-payment and certain other amounts unpaid by payor. This paragraph does not apply to self pay patients.
4. **Medicare Patients.** I certify that the information given by me in applying for payment under Title XVIII or Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for the claim for this service, or a related Medicare claim.
5. **Consent to Medical or Surgical Treatment.** I, the undersigned, consent to the procedure(s) that may be performed during this office visit, including emergency treatment or services, if required, or other services rendered under the general and special instructions of the healthcare practitioners involved in my care. In the event an employee is accidentally exposed to my blood/body fluids, I hereby consent to testing of my blood as deemed necessary by Radiology Regional Center or my attending primary care physician, to include hepatitis and HIV testing. I also acknowledge that no guarantee or warranty has been made by the healthcare practitioner involved in my care or Radiology Regional Center as to the results of any treatment or diagnostic or operative procedure which may be given or performed.
6. **Personal Valuables.** I hereby release Radiology Regional Center and its healthcare practitioners from all responsibility relative to the loss of or damage to money and/or valuables and/or property while receiving services at Radiology Regional Center's facility.
7. **Financial Agreement.** I, the undersigned, agree, whether I sign as a parent, guardian, spouse, agent, guarantor, or as a patient, that in the consideration of the services to be rendered to the patient, I hereby individually obligate myself to pay the account of Radiology Regional Center in accordance with the regular rates and terms of Radiology Regional Center. Should the account be referred to an attorney or collection agency for collection, I shall pay actual attorney's fees and collection expenses. Each of the undersigned hereby consents to Radiology Regional Center's inquiries into his/her credit history in conformity with legitimate business needs and applicable laws, rules and regulations. Each of the undersigned agrees to pay all balances due and payable at the time of the patient's discharge from Radiology Regional Center. Each of the undersigned agrees that Radiology Regional Center may, with or without notice, assign, transfer and convey to any agency or attorney, its right, title and interest in any balance due after the patient's discharge. If suit is filed, the undersigned agrees to pay whatever additional costs, damages, fees and expenses are incurred in pursuing such claim, which may be determined as reasonable, by the court. This paragraph may not apply if your referring provider has made other arrangements for payment with Radiology Regional Center.
8. **Consent to Receive Communication.** If at any time I, or a person I am responsible for, provides contact information (a wireless or landline telephone number or mailing address) at which I may be contacted, I consent to receive communication in any manner, including, but not limited to, automated emails, voice mails, written statements, texts, auto-dialed calls and prerecorded messages, which could result in charges to me. This consent to receive communication may pass on to Radiology Regional Center's successors and assigns, other medical providers used during the course of treatment, affiliates, agents, and independent contractors, such as servicers and collection agents. I understand that my contact information may be used only for treatment, payment, and healthcare operations purposes. ***Radiology Regional Center does not sell its patient list or patient contact information.*** I acknowledge that I am an authorized user of this contact information and that I have permission to use said contact information from the actual current subscriber of the information. It is my responsibility to update this healthcare provider with new and updated contact information and that, if I fail to update this information, I will hold the healthcare provider harmless for untimely notifications. I understand that providing this consent for communication is a condition for treatment at Radiology Regional Center.

   Home# _____ and/or **Cell#** _____

   I understand that I can change my mind by notifying optout@radiologyregional.com.
9. **Adverse Benefit Determination.** Radiology Regional Center is allowed full discovery of any and all information, documentation, policies, procedures and resources used by my health insurance carrier or other health benefit plan to perform an adverse benefit determination, as defined in 29 CFR 2560-503-1 of my covered health benefits. Radiology Regional Center is authorized to represent me in any and all federal lawsuits against my insurance company pursuant to ERISA. Radiology Regional Center is hereby authorized to initiate on my behalf any complaints regarding my healthcare benefits or adverse benefit determinations as defined in 29 CFR 2560-503-1, with the State Insurance Commissioner for a possible violation of state insurance laws or the Employee Benefits Security Administration and the Secretary of Labor as it pertains to ERISA, specifically 29 USC 1003(a) and 1144(a).
10. **Clinical Trial Patients.** Paragraphs 1,2,3,4,7, and 9 do not apply to patients who are receiving this episode of care under a clinical trial which is billed directly to the ordering investigator. **Those paragraphs would apply if additional non-clinical trial exams are performed at this same appointment and only to those services.

I am scheduled to have medical services performed at a Radiology Regional Center facility on _____. I hereby certify and state that I have read, that I fully and completely understand the above Authorization for Medical Services, and that I have signed this Authorization for Medical Services knowingly, freely and voluntarily in advance of that date of service.

Date:

X _____ **X** _____ _____

Patient/Spouse/Parent/Guardian Signature | **Print Name** | **Relationship to Patient**

RADIOLOGY Regional

Patient Information

(Please Print)

Patient Name: _____ **DOB**: _____ **Gender:** ❑ **M** ❑ **F**
Last First Middle

Local Address:_____**City:** _____ **State:** ____ **Zip Code:** _____

Cell Phone:_____ **Home Phone:** _____

Smoking Status: ❑ **Current Smoker** ❑ **Former Smoker** ❑ **Never Smoked** ❑ **Occasional Smoker**

Email Address:_____

Emergency Contact Name: _____ **Phone Number:** _____

RADIOLOGY Regional
Powered by LucidHealth

Protected Health Information (PHI) Disclosure Authorization

Patient Email Address: _____

By providing your email address, you agree to receive email notices from RRC, including notifications regarding your patient portal account or PowerShare, our Image Sharing product.
If you register for the portal or PowerShare with a shared email account, please be advised that all users of that email account may gain access to the medical information contained within the portal or PoweShare and may be able to access and/or reset the password for the portal or PowerShare. If you wish to protect your medical information from such access, do not register for the portal or PowerShare with a shared email account or share your email password with anyone.
****Emailed records sent to an unencrypted email address may be viewable by an unauthorized party. By selecting this delivery method, you understand and accept the inherent risks of receiving records via email to the address you specify.***

Emergency Contact Name: _____ **Phone:** _____

RRC may release any information to the family and friend(s) you list below. (copies of exams, test results, appointment times & dates, medical & financial information)

Name:	**Relationship:**
_____	_____
_____	_____
_____	_____

Create a security password _____ (To access your account if requesting information by phone)

I understand that I can revoke this authorization at any time by written request to RRC and that it is otherwise valid for one year. I understand that RRC may not condition treatment, payment, enrollment, or eligibility of benefits on whether I sign this authorization. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer subject to applicable privacy laws.

Patient Signature: _____ **Date:** _____

Print Name: _____ **Birth Date:** _____

Guardian/Representative Signature: _____ Date: _____

Relationship to patient: _____

*** Please Complete Form on the Back ***

Acknowledgment of Receipt of Notice of Privacy Practice

By signing this form, you acknowledge that you have received or have been informed that you have the right to receive a copy of Radiology Regional Notice of Privacy Practice.

This notice is available in hard copy by verbally requesting a copy at the front desk of any Radiology Regional facility or by submitting a request in writing to the HIPAA Privacy Officer at Radiology Regional, 3660 Broadway, Ft. Myers, FL 33901.

You may also view and/or print a copy of the Notice of Privacy Practice by visiting Radiology Regional website at www.radiologyregional.com, select the **About Us** tab and click on the **Privacy Policy** option.

Patient Signature: _____ **Date:** _____

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

Guardian/Representative Signature: _____ Date: _____

Relationship to Patient: _____