Demographics

Patient Name: _____ Gender: ☐ Male ☐ Female

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

PLEASE CHECK ALL THAT APPLY OR YOU MAY CHOOSE TO DECLINE:

Race: ____**Decline** ____**American Indian or Alaska Native** ____**Asian** ___**Black or African American**
____**Native Hawaiian or Other Pacific Islander** ____**White**____**Other Race**

Ethnicity: ____**Decline** ____ **Hispanic** ____ **Non Hispanic**

Address: _____
Street Apt #

_____
City State Zip code

Phone: (_____) _____--_____ Cell: (_____)_____--_____ Work: (_____) _____--_____ ext:_____

Residence Status: (If Applicable) _____***Skilled Nursing Facility*** _____ ***Nursing Home*** _____ ***Hospice*** _____***Other Assisted Living***

Name of Facility: _____

Facility Address: _____

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_____ Policy 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 Specialists and Dr. Daniel K. Beirne M.D. will gladly bill your Insurance Company for the sedation and refund you if payment is received.
*Our practice prohibits the unauthorized or secret recording of confidential, proprietary or personal information and personal images or voices while in our facility.
***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 Specialists, Dr. Daniel K. Beirne 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 may results in an office fee charge to the patient. The fee will be dependent on the study.**

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

****Minor Consent****

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

_____ _____/_____/_____
Parent or Guardian Signature Date

Screening Form

Patient Name: _____**Date of birth:** __/__/__

Gender: ☐ Male ☐ Female **Weight:** _____ **Height:** _____

Please list your *Symptoms* _____

What is the severity of your symptoms? ☐ None ☐ Mild ☐ Moderate ☐ Severe

Is this related to a Motor Vehicle accident? ☐ YES ☐ NO **Is this 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*: _____
_____ .

What kind of reaction did you have?

_____

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

_____

HEARING AID & DENTAL WORK MUST BE REMOVED FOR IMAGING

Please Check YES or NO:

☐Yes ☐ No Claustrophobic

☐Yes ☐ No Pacemaker (provide card)

☐Yes ☐ No Cardiac Defibrillator (Provide copy of card)

☐Yes ☐No Stents in last 6 weeks (For Cardiac Stents provide card)

☐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 Hypertension (high blood pressure)

☐Yes ☐No Multiple Myeloma (cancer in cells)

☐Yes ☐No Other Heart Problems: (Specify):_____

☐Yes ☐No ABN fast ht rate

☐Yes ☐No Chest Pain with SOB (INFORM STAFF IMMEDIATELY)

☐Yes ☐No Asthma / Hay fever

☐Yes ☐No Emphysema / COPD

☐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 of card)

☐Yes ☐No Hearing Aid

☐Yes ☐ No Yearly Flu Shot

☐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

☐Yes ☐No Pneumonia Vaccine in Last 5 years

☐Yes ☐No Labs drawn within 1 month
Date and Place:
_____
_____

Please list any OTHER medical condition we should be aware of:_____
Please list prior surgeries & approximate dates:_____
_____

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

Imaging Facility: _____Test: _____ Year:_____
City/State_____ Facility Tel: _____-_____-_____

Social History: Do you consume alcohol? ☐ Y ☐ N Do you use tobacco? ☐ Y ☐ N

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

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 Specialists or Dr. Daniel K. Beirne M.D. of **any** changes in my medical history.

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

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

ASSIGNMENT OF BENEFITS & 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 overdue 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 amount 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.

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 give my permission to Beach Medical Imaging/Beach Medical Specialists and their staff to release my medical information to the following people and/or doctors listed below:

_____

_____

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.

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 of Patient (Print)_____ Patient Date of Birth_____

Name of Guardian (if applicable)_____

Signature_____ Date_____

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

FINANCIAL POLICY

Beach Medical Imaging and Specialists now requires that each patient place a credit card on file in order to receive services at our facility. Payment for services rendered is expected at the time of appointment. Patient or Guarantor(s) accepts responsibility for all charges. Any other payment arrangements must be made **in advance** of services rendered as applicable. As you may be aware, the current healthcare market has resulted in insurance policies increasingly transferring costs to you, the insured. Some insurance plans require deductibles and copayments in amounts not known to you or us at the time of your visit.

Insurance:

Beach Medical may, on the Patient's behalf, verify benefits for insurance coverage when provided. Assignment of benefits is not a guarantee of payment. Prior Authorizations are not a guarantee of payment. Secondary insurance, when applicable, is not a guarantee of payment. The patient reserves the right to use insurance at their discretion. All Patient fees pertaining to their responsibility based on insurance policy (Deductible, Co-insurance, Co Pay, or Patient Responsibility), services deemed non covered charges, or Non-Insurance Cash Pay status will be billed to the Patient or Guarantor.

Missed Appointments / Late Cancelations:

Missed Appointments are a cost to us, you, and other patients who have scheduled appointments. Patient care is a high priority and fees are not punitive, but ensure preservation of quality of care. Cancelations are requested 24 hours prior to appointment. We reserve the right to charge for missed appointments or late cancelations up to 50% of the service or procedure cost. Patients who miss / cancel appointments without proper notification may be discharged from the practice. We may require rescheduling for patients who arrive late for appointments.

I have read and understand the Financial Policy. I agree to assign insurance benefits as necessary for treatment. I also agree that if it becomes necessary to submit my account to collections, in addition to the amount owed, all collection fees will be added to my account balance.

Returned Payment Fee: If your bank returns an EFT or check unpaid for any reason, you agree to pay a "Returned Payment Fee" of $25.00

I authorize payment to be applied to all charges deemed the Patient's responsibility as assigned by applicable insurance payer or provider. Charges may not exceed allowable, usual and/or customary applicable fee schedules. In all confidentiality as governed by FL Statue, Beach Medical Imaging & Specialists has permission to hold my payment information in my confidential medical record for payment assignment under HIPAA compliance regulations. All confidential information will be protected, and never at any time, be shared or disclosed to any outside or 3rd party entity. Your payment information will be kept on file for a **maximum** of 1 year or until all outstanding balances have been paid in full.

Visa / MC / Amex / Disc CARD #_____EXP DATE _____/_____

Print Patient Name: _____ DOB:_____

Patient or Guarantor Signature:_____ DATE:_____