CLEARVIEW DIAGNOSTIC
Focus Precision MRI Specialist

ACR AMERICAN COLLEGE OF RADIOLOGY

8076 South Orange Blossom Trail
Orlando FL 32809
Phone: 407-704-3333 Fax: 407-601-1963

"PIP"

LAST NAME: _____ FIRST NAME: _____ MI: ____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP CODE: _____
DATE OF BIRTH: _____ SEX: M OR F PH #: _____
MARITAL STATUS M S D W REFERRING DOCTOR: _____

INSURANCE COMPANY: _____
POLICY: _____ # CLAIM #: _____ DED $_____
INSURED NAME: _____
RELATIONSHIP: _____ SSN: _____ DOB: _____

IS THIS VISIT RELATED TO AN AUTOMOBILE ACCIDENT? YES OR NO
IF SO, DATE OF ACCIDENT: _____/ _____/_____
WHEN DID YOU FIRST BEGIN TREATMENT? _____
APPROXIMATELY, HOW MANY TIMES A WEEK DO YOU ATTEND YOUR TREATMENTS:
"PLEASE CIRCLE" (1) (2) (3) (4) (5) (6)
DID YOU GO TO ANY HOSPITAL? YES OR NO

PRIVATE INSURNACE AUTHORIZATION FOR ASSIGNMENT OF MEDICAL BENEFITS AND INFOMATION RELEASE:

I, UNDERSTAND, AUTHORIZED PAYMENT OF MEDICAL BENEFITS TO THOMAS TUREK, MD. D/B/A CLEARVIEW DIAGNOSTIC FOR ANY SERVICES FURNISED TO ME BY THE PHYSICIANS. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE OR ANY AMOUNT NOT COVERED BY MY CONTRACT. I ALSO AUTHORIZE YOU TO RELEASE TO MY INSURANCE COMPANY INFORMATION CONCERNING HEALTH CARD, ADVICE, TREATMENT OR SUPPLIES PROVIDED TO ME. THIS INFORMATION WILL BE USED FOR THE PURPOSE OF EVALUATION AND ADMINISTERING CLAIMS OF BENEFITS.

PRINT NAME: _____ SIGNATURE: _____
RELATIONSHIP TO PATIENT: _____ DATE: _____/_____/_____

HIPPA

Health Insurance portability and Accountability Act

In accordance to the law regulations effective April 2003 all patient information must be kept confidential and must not be given to anyone who is not authorized.

Clearview Diagnostic, CORP.
8076 South Orange Blossom Trail Orlando, FL 32809

ASSIGNMENT OF INSURANCE BENEFITS , & DEMAND RELEASE

Aseguradora y el paciente lea atentamente lo siguiente en su totalidad

I, the undersigned patient/insured knowingly, voluntarily and intentionally assign the rights and benefits of my automobile Insurance, also known as Personal Injury Protection (PIP), and Medical Payments policy of insurance to the above health care provider, including the right to file a law suit to seek payment of any unpaid PIP benefits, penalty, postage and/or interest. It is the intention of the provider to accept this assignment in lieu of demanding payment at the time services are rendered and that this document will allow the provider to file suit against an insurance company for payment of the insurance benefits. This allows the provider to file suit against an insurance company for payment of the insurance benefits. This assignment of benefits includes overdue interest payments and any potential claim for common law or statutory bad faith. The undersigned directs the insurer to pay the health care provider directly.

The insurer is directed by the provider and the undersigned 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 health provider and the insurer as to the amount payable under the insurance policy or contract. The provider hereby objects to any reduction or partial payments. 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. Please send a copy of any scheduled defense examinations or examination under oath to this provider.

Release of information: I hereby authorize this provider to furnish an insurer, and insurer's intermediary, and the patient's attorney via mail, fax, or email, with any and all information that may be contained in the medical records; to obtain insurance coverage information in writing (declaration sheet) and telephonically from insurer' request from any insurer all explanation of benefits (EOBs) for all providers and non-redacted PIP payout sheets' obtain any statements the patient provided to the insurer; obtain copies of all medical records, X-rays, IMEs, and MRIs, from any other medical provider or any insurer. The provider may produce my medical records to its attorney in connection with any pending lawsuits. The insurer is directed to keep the patient's medical records private and confidential and is not authorized to provide these medical records to anyone without the patient's and the provider's prior express written permission.

Demand/PIP Log Request: Pursuant to 627.4137 Florida Statute 2018, demand is hereby made for the insurer to pay all bills within 30 days without reductions and to mail the latest non-redacted PIP log and the insurance coverage declaration sheet to the above provider within 15 days. The insurer is directed to pay the bills in the order they are received. However, if a bill from this provider and a claim from anyone else are received by the insurer on the same day the insurer is directed to not apply this provider's bill to the deductible. If a bill from this provider and claim from anyone else e is received by the insurer on the same day then the insurer is directed to pay this provider first before the policy is exhausted. In the event this provider's medical bills are disputed by the insurer for any reason the undersigned 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.

Certification: I certify that: I have read and agree to the above.

Caution: Please read before signing. If you do not completely understand this document please ask us to explain in to you. If you sign below, we will assume you understand and agree to the above.

Patient's Name: _____ Patient's Signature: _____

(Please Print) (If patient is minor, signature of parent)

Date: _____/____/_____

Month/Day/Year

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PREGNANCY CONSENT FORM

ANY DIAGNOSTIC TEST DEALING WITH RADIATION SUCH AS AN MRI, X-RAY, CT-SCAN, BONE DENSITY AND MAMMOGRAM TAKEN DURING PREGNANCY MAY BE DANGEROUS TO THE UNBORN CHILD. THEREFORE, YOU ARE ASKED TO IMMEDIATELY INFORM OUR OFFICE IF THERE IS ANY POSSIBILITY THAT YOU MAY BE PREGNANT.

I_____, CERTIFY THAT **I AM NOT PREGNANT** AND AUTHORIZE CLEARVIEW DIAGNOSTIC CENTER TO PERFORM ANY RADIOLOGIC TESTING.

SIGNATURE:_____ DATE:_____

FORMULARIO DE CONSENTIMIENTO POR EMBARAZO

CUALQUIER TIPO DE EXAMENT QUE ENVUELVA RADIACION, COMO ESTOS: MRI, RADIOGRAFIA, TOMOGRAFIA COMPUTADA, DENSITOMETRIA OSEA O MAMOGRAFIA, REALIZADOS DURANTE EL EMBARAZO PUEDE SER EXTREMADAMENTE PELIGROSOS PARA SU BEE, POR LO TANTO LE PEDIMOS QUE NOS INFORME SI EXISTE ALGUNA POSIBILIDAD DE QUE PUEDA ESTAR EMBARAZADA.

YO:_____, CERTIFICO QUE **NO HAY NINGUNA POSIBILIDAD DE QUE ESTE EMBARAZADA** EN ESTE MOMENTO, Y AUTORIZO A CLEARVIEW DIAGNOSTIC CENTRO A REALIZARME UN EXAMENT DE RADIOLOGIA.

FIRMA:_____FECHA:_____

OFFICE OF INSURANCE REGULATION
Bureau of Property & Casualty Forms and Rates

Standard Disclosure and Acknowledgement Form
Personal Injury Protection – Initial Treatment or Service Provided

The undersigned insured person (or guardian of such person) affirms:

1. The services or treatment set forth below were actually rendered. This means that those services have already been provided.

   _____

   _____
2. I have the right and the duty to confirm that the services have already been provided.
3. I was not solicited by any person to seek any services from the medical provider of the services described above.
4. The medical provider has explained the services to me for which payment is being claimed.
5. If I notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in the amounts paid by y motor vehicle insurer. If entitled, my share would be at least 20% of the reduction, up to $500.00

Insured Person (patient receiving treatment or services) or Guardian of Insured Person:

_____	_____	_____
Name (PRINT OR TYPE)	Signature	Date

The undersigned licensed medical professional or medical director, if applicable, affirms the statement numbered I above and also:

A. I have not solicited or caused the insured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.
B. The treatment or services rendered were explained to the insured person, or his or her guardian, sufficiently for that person to sign this form with informed consent.
C. The accompanying statement of bill is properly completed in all material provisions and all relevant information has been provided therein. This means that each request for information has been responded to truthfully, accurately, and in substantially complete manner.
D. The coding of procedures on the accompanying statement of bill is proper. This means that no service has been coded, unbundled, or constitutes an invalid or not medically necessary diagnostic test as defined by Section 627.732 (15) and (16), Florida Statutes or Section 627.736 (5)(b)6, Florida Statutes.

Licensed Medical Professional Rendering Treatment/Services or Medical director, if applicable (Signature by his/her own hand):

_____	_____	_____
Name (PRINT or TYPE)	Signature	Date

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of Claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree per Section 817.234(1)(b), Florida Statutes.

Note: The **original** of this form must be furnished to the insurer pursuant to Section 627.736(4)(b), Florida Statutes and may not be electronically furnished. Failure to furnish this form may result in non-payment of the claim

OFFICE OF INSURANCE REGULATION
Bureau of Property & Casualty Forms and Rates

Standard Disclosure and Acknowledgement Form
Personal Injury Protection – Initial Treatment or Service Provided

The undersigned insured person (or guardian of such person) affirms:

6. The services or treatment set forth below were actually rendered. This means that those services have already been provided.

_____

_____

7. I have the right and the duty to confirm that the services have already been provided.
8. I was not solicited by any person to seek any services from the medical provider of the services described above.
9. The medical provider has explained the services to me for which payment is being claimed.
10. If I notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in the amounts paid by y motor vehicle insurer. If entitled, my share would be at least 20% of the reduction, up to $500.00

Insured Person (patient receiving treatment or services) or Guardian of Insured Person:

✖ _____	✖ _____	✖ _____
Name (PRINT OR TYPE)	Signature	Date

The undersigned licensed medical professional or medical director, if applicable, affirms the statement numbered I above and also:

E. I have not solicited or caused the insured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.
F. The treatment or services rendered were explained to the insured person, or his or her guardian, sufficiently for that person to sign this form with informed consent.
G. The accompanying statement of bill is properly completed in all material provisions and all relevant information has been provided therein. This means that each request for information has been responded to truthfully, accurately, and in substantially complete manner.
H. The coding of procedures on the accompanying statement of bill is proper. This means that no service has been coded, unbundled, or constitutes an invalid or not medically necessary diagnostic test as defined by Section 627.732 (15) and (16), Florida Statutes or Section 627.736 (5)(b)6, Florida Statutes.

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AFFIDAVIT FOR SERVICE RENDERED

STATE OF: _____
COUNTY OF: _____

Before me this day personally appeared: _____, who, being duly sworn, deposes and says:

I declare that the services rendered were reasonable and necessary with respect to the bodily injury sustained. Under penalty of perjury, I have read the foregoing, and facts alleged are true to the best of my knowledge an belief.

✖ _____ ✖ ____/____/____

Patient's Signature Date

✖ _____

Print Name

Sworn to and subscribed before me by the above this_____day of _____, 20___.
My term expires_____, 20___.

Seal:

_____
Notary Public

HIPPA

Health Insurance Portability and Accountability Act

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LETTER OF PROTECTION

First Name: _____ Last Name: _____
Date of Birth: _____ Social Security Number: _____
Date:_____ Referred By: _____

I hereby authorize Clearview Diagnostic to furnish you _____ my attorney, with a full report of their examination, diagnostic testing, etc. myself in regard to the accident in which I was involve on _____ I hereby authorize you, my attorney. To pay directly to Clearview Diagnostic such sums as may be due and owing them for professional services rendered to me both by reason of this accident and other bill that due their office and to withhold such sum from any settlement judgment, or verdict as may be necessary to adequately protect Clearview Diagnostic. I hereby give a lien on my case to Clearview Diagnostic against any and all proceeds of any settlement, judgment, or verdict which may be paid to you, my attorney or myself, as a result of my injuries for which I have been treated, or injuries in connection therewith. This lien shall be in effect until such time as both myself and Clearview Diagnostic agree to forgive it in writing or until said debts is paid in full. I fully understand that I am directly and fully responsible to said provider for all professional bill s submitted by them for services rendered to me and the agreement is made solely for them awaiting payment and is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fee.

Patient Signature: _____ Date: _____/_____/_____

The undersigned, being attorney of record for the above patient does hereby agree to observe all the terms of the above and aggress in withhold such sums from the settlement, judgment, or verdict as may be necessary to adequately protect Clearview Diagnostic.

Attorney's Signature: _____ Date: _____/_____/_____

POWER OF ATTORNEY TO ENDORSE CHECKS

KNOWN ALL MEN OF THESE PRESENT That the undersigned has made constituted and by these presents does hereby make, constitute and appoint Clearview Diagnostic, be the undersigned's true an lawful attorney for and in the undersigned's orders which are made payable to the undersigned alone of the undersigned and the said Clearview Diagnostic, which said checks drafts and/or money orders are to pay for medical services or like which have been performed by Clearview Diagnostic at my request, or with my knowledge and approval of the undersigned and/or the maker of the check, draft or money order.

The undersigned by these presents does not give and grant unto the said Clearview Diagnostic. As attorney the full power and authority to do and perform all and every act and thing, whatsoever requisite and necessary to be done in and about the might or could do to personally present insofar as the endorsing and cashing of said checks, draft or money orders are concerned.

The undersigned does hereby ratify and confirm any taken by the said attorney in accordance with this special power of attorney and which the said attorney shall do cause to be done by virtue of these presents.

IN WITNESS WHEROF, the undersigned has here unto set his/her hand this
_____ Day of_____, 20____.

_____ _____
Witness Patient's Signature

CLEARVIEW DIAGNOSTIC
Focus Precision MRI Specialist

ACR AMERICAN COLLEGE OF RADIOLOGY

CONFIDENTIAL

INFORMED CONSENT FOR IMAGING STUDIES

Name: _____ Date of Birth ____/____/____

I understand that as a patient, I am eligible to receive a range of services at **Clearview Diagnostic**. The goal of the assessment process is to determine the best course of treatment for me. I understand that all information shared with the clinicians at **Clearview Diagnostic.** Is confidential and no information will be released without my consent. I understand that my doctor has discussed the risks and benefits with me in base of my imaging studies. In all other circumstances, I consent to release information is given through written authorization.

I have also been informed on Advance Directives, Living Will and I understand that **Clearview Diagnostic, Inc. does not honor Advance directives**. In the case of a life threatening situation our emergency protocol will be adhered to

IF PATIENT IS A MINOR:

I am the parent or legal guardian of, _____who is a minor,_____years of age. I authorize the above treatment of this minor which **Clearview Diagnostic, Inc.** may consider necessary or advisable.

If I have any questions regarding this consent form or about the services offered at **Clearview Diagnostic** I may discuss them with the physician and technologist. I have read and understand the above. I consent to participate in the imaging study offered to me by **Clearview Diagnostic**. I understand that I may stop imaging study at any time.

I, _____am consenting for the following imaging study (ies):

- ☐ MRI without contrast
- ☐ CT Scan without contrast
- ☐ CT Scan combined with and without contrast
- ☐ MRI with contrast
- ☐ CT Scan With contrast
- ☐ Stress Test
- ☐ Nuclear Medicine
- ☐ MRI combined with and without contrast
- ☐ Mammography
- ☐ Ultrasound
- ☐ X Ray

By my signature I acknowledge that I have been informed on my rights and responsibilities to refuse any medical imaging study that I may not want.

_____ _____

Signature of Patient/Guardian Date

_____ _____

Name of Parent/Guardian Technologist Signature/Witness

THE FLORIDA PATIENT'S BILL OF RIGHTS AND RESPONSIBILITIES

Florida law requires that your health care provider or health care facility recognize your rights while you are receiving medical care and that you respect the health care provider's or health care facility's right to expect certain behavior on the part of patients. You may request a copy of the full text of this law from your health care provider or health care facility. A summary of your rights and responsibilities follows:

A patient has the right to be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy

A patient has the right to a prompt and reasonable response to questions and request

A patient has the right to know who is providing medical services and who is responsible for his or her care.

A patient has the right to know what patient support services are available, including whether an interpreter is available if he or she does not speak English.

A patient has the right to know what rules and regulations apply to his or her conduct.

A patient has the right to be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.

A patient has the right to refuse any treatment, except as otherwise provided by law.

A patient has the right to be given, upon request; full information and necessary counseling on the availability of know financial resources for his or her care.

A patient who is eligible for Medicare has the right to know, upon request and in Advance of treatment; whether the health care provider or health care facility accepts the Medicare assignment rate.

A patient has the right to receive, upon request prior to treatment a reasonable estimate of charges for medical care.

A patient has the right to receive a copy of a reasonably clear and understandable, itemized bill and, upon request to have the charges explained.

A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, physical handicap, or source of payment

A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.

A patient has the right to know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.

A patient has the right to express grievances regarding any violation of his or her rights, as stated in Florida law, through the grievance procedure of the health care provider or health care facility which served him or her and to the appropriate state licensing agency.

A patient is responsible for providing to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health

A patient is responsible for reporting unexpected changes in his or her condition to the health care provider.

A patient is responsible for reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.

A patient is responsible for following the treatment plan recommended by the health care provider.

A patient is responsible for keeping appointments and, when he or she is unable to do so for any reason, for notifying the health care provider of health care facility.

A patient is responsible for his or her actions if he or she refuses treatment or does not follow the health care provider's instructions.

A patient is responsible for assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.

A patient is responsible for following health care facility rules and regulation affecting patient care and conduct.

By my signature I acknowledge that I have been informed on my rights and responsibilities to refuse any medical treatment that I may not want.

Patient Signature: _____ Date: _____

Patient Guardian Signature: _____ Witness: _____

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RELEASE CONSENT FORM FOR RECORDS

I_____GIVE AUTHORIZATION TO _____
_____ TO RELEASE MY RECORDS TO CLEARVIEW DIAGNOSTIC.

THANK YOU,

_____ _____

PATIENT'S SIGNATURE DATE