NOTICE OF PRIVACY PRACTICES

Professional Imaging Centers, Inc. (PIC) is required by law to maintain the privacy of your protected health information. This Notice of Privacy Practices tells you how your protected health information may be used and how the PIC keeps your information private and confidential. This notice explains the legal duties and practices relating to your protected health information. As part of the PIC's legal duties this Notice of Privacy Practices must be given to you upon your request. The PIC is required to follow the terms of the Notice of Privacy Practices currently in effect. The PIC may change the terms of its notice. The change, if made, will be effective for all protected health information that it maintains. New or revised notices of privacy practices will be posted on the PIC centers and will be available by email upon request.

Uses and Disclosures of your protected health information

Protected health information includes demographic and medical information that concerns the past, present, or future physical or mental health of an individual. Demographic information could include your name, address, telephone number, social security number and any other means of identifying you as a specific person. Protected health information contains specific information that identifies a person or can be used to identify a person. Protected health information is health information created or received by a health care provider, health plan, employer, or health care clearinghouse. PIC can act as each of the above business types. This medical information is used by PIC in many ways while performing normal business activities. Your protected health information may be used or disclosed by PIC for purposes of treatment, payment, and health care operations. *Health care professionals use medical information in the clinics or hospital to take care of you. Your protected health information may be shared, with or without your consent, with another health care provider for purposes of your treatment. PIC may use or disclose your health information for case management and services. PIC may send the medical information to insurance companies, Medicaid, or community agencies to pay for the services provided to you.* Your information may be used by certain department personnel to improve PIC's health care operations. PIC also may send you appointment reminders, information about treatment options or other health-related benefits and services. Some protected health information can be disclosed without your written authorization as allowed by law. Those circumstances include:

- Reporting abuse of children, adults, or disabled persons.
- Investigations related to a missing child.
- Internal investigations and audits by PIC's divisions, bureaus, and offices.
- Investigations and audits by the state's Inspector General and Auditor General and the legislature's Office of Program Policy Analysis and Government Accountability.
- Public health purposes including vital statistics, disease reporting, public health surveillance, investigations, interventions and regulation of health professionals.
- District medical examiner investigations.
- Research approved by PIC.
- Court orders, warrants, or subpoenas.
- Law enforcement purposes, administrative investigations, and judicial and administrative proceedings.

Other uses and disclosures of your protected health information by PIC will require your written authorization. This authorization will have an expiration date that can be revoked by you in writing. These uses and disclosures may be for marketing and for research purposes. Certain uses and disclosure of psychotherapist notes will also require your written authorization.

Individual Rights

You have the right to request PIC to restrict the use and disclosure of your protected health information to carry out treatment, payment, or health care operations. You may also limit disclosures to individuals involved with your care. PIC is not required to agree to any restriction. **You have the right to be assured that your information will be kept confidential.** PIC may mail or call you with health care appointment reminders. We will make contact with you in the manner and at the address or phone number you select. You may be asked to put your request in writing. If you are responsible to pay for services, you may provide an address other than your residence where you can receive mail and where we may contact you. **You have the right to inspect and receive a copy of your protected health information.** Your inspection of information will be supervised at an appointed time and place. You may be denied access as specified by law. If access is denied, you have the right to request a review by a licensed health care professional who was not involved in the decision to deny access. This licensed health care professional will be designated by PIC.

You have the right to correct your protected health information. Your request to correct your protected health information must be in writing and provide a reason to support your requested correction. PIC may deny your request, in whole or part, if it finds the protected health information:

- Was not created by PIC,
- Is not protected health information,
- Is by law not available for your inspection, or
- Is accurate and complete.

If your correction is accepted, PIC will make the correction and tell you and others who need to know about the correction. If your request is denied, you may send a letter detailing the reason you disagree with the decision. PIC will respond to your letter in writing. You also may file a complaint, as described below in the section titled Complaints.
You have the right to receive a summary of certain disclosures PIC may have made of your protected health information. This summary does **not** include:

- Disclosures made to you.
- Disclosures to individuals involved with your care.
- Disclosures authorized by you.
- Disclosures made to carry out treatment, payment, and health care operations.
- Disclosures for public health.
- Disclosures for health professional regulatory purposes.
- Disclosures to report abuse of children, adults, or disabled.
- Disclosures prior to April 14, 2003.
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This summary **does** include disclosures made for:

- Purposes of research, other than those you authorized in writing.
- Responses to court orders, subpoenas, or warrants.
- You may request a summary for not more than a 6-year period from the date of your request.
- If you received this Notice of Privacy Practices electronically, you have the right to a paper copy upon request.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with the: Department of Health's Inspector General at 4052 Bald Cypress Way, BIN A03/ Tallahassee, FL 32399-1704/ telephone 850-245-4141 and with the Secretary of the U.S. Department of Health and Human Services at 200 Independence Avenue, S.W./ Washington, D.C. 20201/ telephone 202-619-0257 or toll free 877-696-6775. The complaint must be in writing, describe the acts or omissions that you believe violate your privacy rights, and be filed within 180 days of when you knew or should have known that the act or omission occurred. PIC will not retaliate against you for filing a complaint.

For Further Information

Requests for further information about the matters covered by this notice may be directed to the person who gave you the notice, to the director or administrator of PIC facility where you received the notice, or to the Department of Health, Inspector General at 4052 Bald Cypress Way, BIN A03/ Tallahassee, FL 32399-1704/ telephone 850-245-4141.

References

"Standards for the Privacy of Individually Identifiable Health Information; Final Rule." 45 CFR Parts 160 through 164. *Federal Register,* Vol. 65, No. 250 (December 28, 2000).
"Standards for the Privacy of Individually Identifiable Health Information; Final Rule." 45 CFR Parts 160 through 164. *Federal Register,* Vol. 67, No. 157 (August 14, 2002).

Effective Date

This Notice of Privacy Practices is effective beginning June 6, 2007, and shall be in effect until a new Notice of Privacy Practices is approved and posted.

Acct_____

PROFESSIONAL IMAGING CENTERS
PROFESSIONAL IMAGING CONSULTANTS

HOLTER MONITOR INFORMATION SHEET

PATIENT NAME: _____

DOB: _____ **SEX: F M**

REFERRING PHYSICIAN: _____

START DATE: _____ **START TIME:** _____:_____

HOLTER # _____ **CARD#** _____

PACE MAKER: YES_____ **NO** _____

_____
TECHNOLOGIST

PROFESSIONAL IMAGING CENTERS, INC.
1049 WILLA SPRINGS DR., STE 1051
WINTER SPRINGS, FL 32708
Phone: (407) 657-7979 FAX (407) 657-7979

HIPPA AND DISCLOSURE AUTHORIZATION FOR INFORMATION REQUEST

Patient Name: _____ Date of Birth: _____

I acknowledge that a copy of the Notice of Privacy Practices that outlines how patient confidential information will be used, disclosed, protected, and how I can get access to this information, is available to me upon request.

Pursuant to the Health Insurance Portability and Accountability Act (HIPPA), I hereby authorize the following providers: (List all providers from whom information is being sought) to disclose the following protected health information to Professional Imaging Centers and/or Professional Imaging Consultants.

_____

_____

(Check as applicable)

□ Copies of any diagnostic imaging tests taken within the past seven years.
□ Medical history, including specific progress notes regarding any problems that would impact surgery or procedure's progress or outcome.
□ A list of allergies.
□ Results of relevant diagnostic or laboratory tests.
□ Other:

_____

This protected health information is being used by the facility for the purpose of preparation for an outpatient procedure at Professional Imaging Centers and/or Professional Imaging Consultants.This authorization shall be in force and effect until: _____/_____/_____

I understand that, as set forth in the health care facility's Privacy Notice, I have the right to revoke this authorization, in writing at any time by sending written notification to:

Professional Imaging Centers -Attn: Privacy Officer
1049 Willa Spring Dr., STE 1051; Winter Springs, FL 32708

- I authorize Professional Imaging Centers to release films and/or reports regarding my radiographic exams to treating healthcare providers that will be providing medical treatment or service to me.
- I understand that a revocation is not effective to the extent that the health care facility has relied on the use or disclosure of the protected health information.
- I understand that information used and disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
- I understand that the health care facility will not condition my treatment on whether I provide authorization for the requested disclosure.

_____ _____/_____/_____
Signature of Patient or Personal Representative Date

_____ _____
Print Patient's Name or Personal Representative Description of Personal Representative's Authority

Fax Reports To: Professional Imaging Centers _____Attn: _____

Patient Will Pick- Up on_____

Courier Will Pick- Up on _____Courier Name_____

PATIENT COMPLIANCE FORM

THIS INFORMATION IS FOR ELECTRONIC MEDICAL RECORDS IN COMPLIANCE WITH NEW MEDICARE REGULATIONS. PROFESSIONAL IMAGING CENTERS, INC IS IN COMPLIANCE WITH ALL CONFIDENTIALITY LAWS UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPPA).

DATE:_____ ACCOUNT: _____

PATIENT'S NAME: _____

SEX: _____ MALE _____ FEMALE

Language ☐ Spanish ☐ English

Race ☐ American Indian Alaskan Native ☐ Hawaiian or Pacific Islander ☐ Asian

☐ Caucasian ☐ Black or African American ☐ Refused to Answer ☐ Other

Ethnicity ☐Hispanic or Latino ☐Non Hispanic or Latino ☐ Refused to Answer

DO YOU CURRENTLY SMOKE: _____ YES _____ NO IF NO, HAVE YOU EVER SMOKED _____ YES _____ NO

LIST ANY KNOWN ALLERGIES TO MEDICATIONS:

_____

_____

MEDICAL HISTORY OR SYMPTOMS NON-RELATED TO TODAY'S VISIT:

_____

_____

_____

_____

CURRENT MEDICATIONS YOU ARE TAKING:

_____

_____

_____

RELEASE OF PROFESSIONAL IMAGING CENTERS' RECORDS (REQUIRES 48 HOURS NOTICE):

I hereby authorize Professional Imaging Centers, to release information and/or copies of my medical records to any guarantor of payment on my account, any insurance company for which benefits have been assigned, and /or to the person (s) listed below:

Name:_____ Relationship: _____

Name:_____ Relationship: _____

Name:_____ Relationship: _____

_____ _____

PATIENT'S SIGNATURE GUARANTOR'S SIGNATURE

Account #: _____ Date: _____

Patient's Name: _____ Date of Birth: _____ Social Security: _____

Guarantor Name: _____

Address: _____CITY/STATE_____Zip Code:_____

Phone: _____ Cell: _____ Work / Other: _____

Referring Physician: _____ Phone Number _____ Fax _____

Primary Insurance: _____ Policy No: _____

Secondary Insurance Name and Policy #: _____

Attorney Contact Name and Phone Number: _____

Is the above information accurate and correct? Yes _____ No _____ (write correct address/phone number below)

_____

We do require you to pay your co-payments and deductibles at the time of service. We accept cash, checks, Visa, Master Card, and American Express. Please understand that any monies collected at the time of visit are only an estimated amount of your financial responsibility and do not represent the total financial responsibility due for the services rendered. In most cases, we will bill your insurance for you. **Please understand that this is a courtesy to our patients, not our responsibility**. Your insurance contract is between you and your insurance company. It is **YOUR** responsibility to understand the terms and benefits, which are a part of your contract. If you are unsure what your benefits are, you should contact your benefits department for verification prior to your visit.

I have read the foregoing, have received a copy thereof (upon my request), and I am personally empowered, or am duly authorized by the patient, as patient's general agent to execute the above, It is my responsibility to consult with my insurance company regarding payment and authorizations required prior to my visit. I hereby assign to Professional Imaging Centers, Inc reimbursement benefits of all insurance policies and/or settlements otherwise payable to the patient for service rendered. I authorize Professional Imaging Centers, Inc to submit claims to insurance companies plan administrators, and/or attorneys and to apply insurance proceeds to Professional Imaging Centers, Inc. If refunds are due under the provision of such insurance policies, I also assign all rights, as the insured, to bring an action against my insurance company for benefits due under the insurance policies.If your insurance company has not paid your bill in full within 60 days, you will be expected to pay in full the balance. Any balance due from you after your insurance has paid will be due within 30 days from receipt of your statement. In the event of a large balance due, we can arrange a payment plan suitable for all parties concerned.

_____

PATIENT'S SIGNATURE

_____ _____

Guarantor (if other than patient) Parent or Legal Guardian Relationship to Patient

_____FOR OFFICE USE ONLY_____

Today's Financial Responsibility $_____ **Previous Balance $~PTBAL** **Other Amts Due $~CBAL** **Total Due $**_____

Cash, VS, MC, AMEX, Disc, Check/Check No.

Payment by _____#_____ Payment Amount $_____ Balance Due $_____ Taken by_____

CC REPORT TO: _____ INS ACTIVE: _____ 2ND INS ACTIVE: _____

AUTHORIZATION CPT CODE_____ DOS_____EXP DATE_____ AUTH #_____

AUTHORIZATION CPT CODE_____ DOS_____EXP DATE_____ AUTH #_____

AUTHORIZATION CPT CODE_____ DOS_____EXP DATE_____ AUTH #_____

PRIOR STUDIES: _____

TECH _____ RAD _____ CT / MR CONTRAST CPT CODE _____UNIT #: _____ML

CPT CODE	INTERNAL STUDY CODE	CPT CODE	INTERNAL STUDY CODE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Account #:_____ PATIENT INFORMATION DOS:_____

PATIENT: _____ **DOB:** _____

SEX: _____ MALE _____ FEMALE WEIGHT: _____

FEMALE PATIENTS: **PREGNANT YES NO (circle one)** **LAST MENSTRUAL PERIOD** _____

With the full understanding of the above, I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this time and I wish to have a radiographic examination performed now. There is a risk in the of radiation and the possiblity that it will harm a fetus; thus, if there is a chance that you are pregnant, you should not participate in the study before having a test to confirm non-pregnancy. (_____) Please initial.

CIRCLE IF YOU HAVE OR EVER HAD:

ALLERGIC REACTION TO CONTRAST, IODINE, OR SHELLFISH HYPERTENSION/ HIGH BLOOD PRESSURE
CARDIAC PACEMAKER HEART DISEASE METAL IMPLANTS IN YOUR BODY
ASTHMA OR RESPIRATORY DISEASE HEART SURGERY REMOVABLE DENTAL WORK
BRAIN ANEURYSM CLIP ELECTRICAL STIMULATOR RENAL (KIDNEY) DISEASE METAL SHRAPNEL/FRAGMENTS DIABETES TATTOO/PERMANENT MAKE UP

CANCER HISTORY: _____

PRIOR SURGERY HISTORY (TYPE & DATE) _____

ARE YOU CURRENTLY TAKING METFORMIN _____ YES _____ NO GLUCOPHAGE _____ YES _____ NO

PRIOR EXAMS RELATED TO TODAY'S STUDY (FACILITY NAME,DATE,EXAM TYPE): _____

_____

Emergency Contact: _____ Relation: _____ Phone Number: _____

CONTRAST PATIENTS ONLY:

**You may be receiving an intravenous contrast media and/or oral contrast media to enhance the visibility of certain tissues. Possible side effects include, but are not limited to: nausea,a warm flushed feeling, potential allergic reaction including, but not limited to hives, wheezing, difficulty breathing in rare cases, anaphylactic shocks _____ (INITIAL)

*I,the undersigned, verify that all the answers I have provided are true to the best of my knowledge. I give Professional Imaging Centers the permission to perform the examination(s) requested by my physician. I have read the above and fully understand its contents and all my questions have been answered.

_____

~PN OR PARENT/LEGAL GUARDIAN

DO NOT WRITE BELOW THIS LINE

EMR COMPLETED: YES/_____ MVA OR DOI:_____ CONTRAST _____

PREVIOUS REPORTS: _____

EXAM: MRI MRA CT CTA XRAY:_____

DX:_____

SYMPTOMS:_____

_____

_____

RADIOLOGIST: _____ TECH: _____ PRIORS: _____

COMMENTS: _____

_____

THE ABOVE DOCUMENT WAS TRANSLATED BY _____ ON _____

BONE DENSITY QUESTIONNAIRE

Account Number_____ Date: _____

Patient's Name: _____

DOB: _____ Race: _____ Weight: _____ Height: _____

Have you ever had a Bone Density / Dexa Scan before? No _____ Yes_____

If yes, When: _____ Where: _____

Results: _____ Normal _____ Osteopenia _____ Osteoporosis

Y____ N____ Do you take any medications for Osteopenia or Osteoporosis?

If yes, What medications:_____

Y____ N____ Do you have a family history of Osteoporosis?

Y____ N____ Have you experienced any height loss?

Y____ N____ Have you gone through menopause? If yes, What age? _____

Natural or Surgical? _____ Where ovaries removed- One or Both _____

Y____ N____ Are you taking any form of hormone replacement therapy?

Y____ N____ Do you take any calcium supplements?

Y____ N____ Had you had any spine surgery? Which part of your spine?_____

Y____ N____ Have you had any fractures as an adult? What body parts? _____

Y____ N____ Have you had any surgeries on your hips? Right ___ Left ___ When _____

Y____ N____ Are you currently taking corticosteroids / steroids?

Y____ N____ Are you currently taking any thyroid medications? How Long? _____ Medication_____

Y____ N____ Do you smoke? How much _____

Y____ N____ Do you drink more than two (2) alcoholic beverages per day?

Which Hand do you write with? Right _____ Left_____

_____

Patient's Signature

For Office Use Only

TECH NAME: _____ RADIOLOGIST NAME: _____

PRIOR EXAMS FOR COMPARISON: DATE: _____EXAM TYPE _____

DX: _____

COMMENTS: _____

PATIENT MAMMOGRAM HISTORY

Account Number: _____ Date of Service: _____

Name: _____ _____

Last Name First name

Date of Birth: _____ Age: _____

Are you PREGNANT now or is there a possibility that you could be pregnant? Yes _____ No _____

How many children have you had? _____ How old were you when you had your first child? _____

Have you had a prior Mammogram? No ____ Yes ____When? _____Where? _____

Are you having any **NEW** breast problems **NOW**? No ___ Yes ____

Distinct lumps in either breast	Right _____	Left _____
Lumpiness (fibrocystic changes)	Right _____	Left _____
Discomfort, pain, or soreness	Right _____	Left _____
Discharge from nipple	Right _____	Left _____

Are you currently taking Hormones? No _____ Yes _____ For how long? _____

Have you had cancer of the: Breast _____ Uterus _____ Ovaries _____ Other _____

Do you have a **FAMILY HISTORY** of breast cancer? No ____ Yes ____ Who? _____

Please mark if **You** have previously had any of the Breast Procedures below:

Needle Biopsy	Right ____ Left ____ When _____	Surgical Biopsy	Right ____ Left ____ When _____
Cyst Aspiration	Right ____ Left ____ When _____	Implants	Right ____ Left ____ When _____
Reduction / Lift	Right ____ Left ____ When _____	Lumpectomy	Right ____ Left ____ When _____
Mastectomy	Right ____ Left ____ When _____	Radiation	Right ____ Left ____ When _____

I hereby undersigned, verify that all the answers I have provided are true to the best of my knowledge. I give Professional Imaging Centers the permission to perform the examination(s) requested by my physician. I have read the above and fully understand its contents and all my questions have been answered.

_____

Patient's Signature

To be completed by Technologist

Tech's Name: _____ Radiologist: _____

Exam: _____ DX: _____

Comments: _____