PATIENT INFORMATION

San Benito Imaging Center
State of the Art Open MRI & Ultrasound

Date: _____
Phone Number:_____
Referring Physician_____
Responsible Party (if a minor) _____
In Case of Emergency (Name) _____ Phone: _____

Patient Name: _____
(Last) (First) (Middle Initial)
Address_____
City_____ State_____ Zip Code_____
Sex: __Male ___ Female Age _____ Birth date _____ Marital Status_____
SS#: _____ Weight _____

Patient Employed By: _____ Business Phone: _____
Address: _____ City: _____ Zip Code: _____
Do you have Medical Insurance? ___Yes ___No →if Yes,

___Medicare ___Medicaid ___ Self Pay ___ Worker's Compensation

Name of Primary Insurer: _____
ID#_____ Group #: _____

Name of Secondary Insurer: _____
ID#_____ Group #: _____
****** Insurance quote of benefits are only an estimate. Patient is responsible for any underpayments and non payments by their insurance company. *** The provider will not file a claim with any other insurance if the patient is self pay. ******

Medical History

Do you have a medical history of renal disease, seizures, asthma, or any other diseases or medical condition? Yes ___ No ___ if yes, please list: _____
Have you had any type of surgeries in the past? Yes___ No___
If yes, please list: _____
Do you have any drug allergies? Yes ___ No ___ if yes, please list: _____
Are you or do you suspect that you are pregnant at this time? Yes___ No___

Authorization for Release of Information

I hereby authorize San Benito Imaging Center to release any medical or other information necessary for the processing of insurance benefits for medical services rendered. I authorize the San Benito Imaging Center to release any medical or other information to other medical care providers or administrative parties for purposes of coordinating and documenting my treatment.

_____ _____
Signature of Patient, Parent, or Guardian **Date**

San Benito Imaging Center
200 N. Sam Houston, San Benito, Texas 78586

Patient Authorization Record

I grant permission to the employees of San Benito Imaging Center to render outpatient diagnostic services to me during my diagnostic testing and to carry out the orders of my attending physician, including consultants, associates and assistants of his choice.

Release of Information

I authorize San Benito Imaging Center to release my medical information requested by my ordering physician, representatives of local, state, federal agency, insurance companies, or other organizations or entities as may be required by said representatives for payment of claims arising from diagnostic testing as are due to San Benito Imaging Center.

Valuables

I agree to assume personal responsibility for all jewelry, money or other valuables brought into San Benito Imaging Center during my scheduled periods. This responsibility includes dentures, eyeglasses, contact lens, pillows, and any other personal items.

Financial Responsibility

I understand that regardless of my assigned insurance benefits, I am responsible for the total charges for services rendered, and I further agree that all amounts are due upon request and are payable to San Benito Imaging Center at Cameron County, Texas.

I further understand that should this account become delinquent and it becomes necessary for the amount to be referred to an attorney or collection agency for collection or suit, I, as designated responsible party, shall pay the reasonable attorney fees or collection expense, and that a statutory lien will be filed against me.

Insurance Assignment

In consideration for services to be rendered, I hereby assign and transfer to San Benito Imaging Center any benefits payable to or for my benefit under hospitalization, sickness or accident insurance, to include major medical or PIP for the payment of such services rendered. I agree to cooperate, aid and assist San Benito Imaging Center in processing all possible insurance benefits including initiation and fulfillment of all policy provisions such as insurance companies may require for payment . I further assign and transfer to San Benito Imaging Center an interest in any course action I may have arising out of injuries directly or indirectly resulting in this diagnostic testing. This assignment includes insurance benefits accruing to me under uninsured motorist coverage.
As a Medicare or Medicaid patient, I certify that the information given by me in applying for payment under title XVIII of the Social Security act is correct. I request that payment of authorized benefits be made on my behalf.
THIS ASSIGNMENT EXTENDS TO THE TOTAL AMOUNT OWED TO SAN BENITO IMAGING CENTER AND ALSO AUTHORIZES APPLICABLE HEALTH CARE BENEFITS, IF ANY, TO BE PAID TO THE PHYSICIAN SPECIALISTS IN THE FIELD OF RADIOLOGY OR ANY OTHER LICENSED PHYSICIANS WHO PERFORM SERVICES AT SAN BENITO IMAGING CENTER.

_____ _____
Patient Signature Date

_____ _____
Signature of Responsible Party Relationship to Patient

_____ _____
Witness Date

200 N. Sam Houston Blvd San Benito, TX 78586 (956) 399-2666

Written Financial Policy

Thank you for choosing San Benito Imaging Center. Our primary mission is to deliver the best and most comprehensive diagnostic care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:
You can choose from:

- Cash, Check, Visa, Mastercard, American Express or Discover Card
- NO INTEREST[1] Payment Plans[2] from CareCredit

  - Allow you to pay over time with NO INTEREST[1]
  - Convenient, low monthly payment plans[2] also available
  - No annual fees or pre-payment penalties

Please note:

San Benito Imaging Center requires payment prior to the beginning of your procedure. If you choose to discontinue your procedure before it is complete, you will receive a full refund.

San Benito Imaging Center charges $25 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you.

_____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please Print) Chart#

[1]If paid within the promotional period. Otherwise, interest assessed from purchase date. Minimum monthly payment required.
[2]Subject to credit approval
[3]However, if we do not receive payment from your insurance carrier within 30 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

If you wish not to receive future advertising faxes from CareCredit, please call CareCredit toll free at (800) 859-9975 or fax your request to (866) 311-2524. Please identify the fax number or numbers covered by your request. If you communicate your request to CareCredit by one of the means identified in this notice, then failure to comply with your request within 30 days is unlawful. If you later provide permission to CareCredit to send you advertising faxes, then CareCredit may lawfully send you advertising faxes.

Notice of Privacy Practices

Fund-raising. Unless you request us not to, we will use your name and address to support our fund-raising efforts. If you do not want to participate in fund-raising efforts, please check off the following box.

☐ Please do not use my information for fund-raising purposes.

Individual Rights
You have certain rights under the federal privacy standards. These include:

☐ the right to request restrictions on the use and disclosure of your protected health information
☐ the right to receive confidential communications concerning your medical condition and treatment
☐ the right to inspect and copy your protected health information
☐ the right to amend or submit corrections to your protected health information
☐ the right to receive an accounting of how and to whom your protected health information has been disclosed
☐ the right to receive a printed copy of this notice

San Benito Imaging Center Duties
We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We also required to abide by the privacy policies and practices that are outlined in this notice.

Rights to Revise Privacy Practices
As permitted by law, we reserve the right to amend or modify our privacy policies and practices. Theses changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information
You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulations, we require that request to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting Office manager or Vice-President privacy official. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints
If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Vice-President
San Benito Imaging Center
200 N. Sam Houston
San Benito, Texas 78586

Notice of Privacy Practices

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address.

You will not be penalized or otherwise retaliated against for filing a complaint.

Contact Person
The name and address of the person you may contact for further information concerning our privacy practices is:

Vice-President
San Benito Imaging Center
200 N. Sam Houston
San Benito, Texas 78586
(956) 399-2666

Effective Date
This notice is effective on or after _____.

Acknowledgment of the Notice

I acknowledge that I have received the Notice of Privacy Practice and that it has also been explained to me.

Patient Name: _____ **Signature:** _____

Patient's Representative: _____ **Signature:**_____

Witness: _____

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures
Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory test and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of San Benito Imaging Center. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement. Your health information may be disclosed to enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government-mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosures of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use of disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information
Appointment reminders. Your health information will be used by our staff to send you appointment reminders.

Information about treatments. Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.